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: 151319	Period: From 10/01/2013 To 09/30/2014	Worksheet S Parts I-III Date/Time Prepared: 2/19/2015 8:49 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/19/2015 Time: 8:49 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] 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 GIBSON GENERAL HOSPITAL (151319) for the cost reporting period beginning 10/01/2013 and ending 09/30/2014 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: 2/19/2015 Time: 8:49 am
Lk25VUOGYsENyxRHLPAAQzIVDJ9zO0
QkrhIOgKRJfSLsNMOPVUSAV.nUD4HC
HOGcO8GChMOSsr8h

PI: Date: 2/19/2015 Time: 8:49 am
66.NOHxogoF4T4KTzHSWjfG1xZ2sCO
tRnGxOrFv3W2fLxZhSfJ.oXZn9Fzvo
H6CsOujDogO5jf.0

(Signed) Officer or Administrator of Provider(s)

Title: VP + CFO

Date: 2-27-2015

PART III - SETTLEMENT SUMMARY

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital	0	262,873	-385,562	0	1,480,423	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	16,143	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	-1		0	9.00
200.00	Total	0	279,016	-385,563	0	1,480,423	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. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 2/19/2015 8:48 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1800 SHERMAN DRIVE	PO Box:			1.00
2.00	City: PRINCETON	State: IN	Zip Code: 47670-	County: GIBSON	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	GIBSON GENERAL HOSPITAL	151319	21780	1	12/16/2003	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	GIBSON GENERAL SWING BED	15Z319	21780		12/16/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	GIBSON GENERAL SNF	155093	21780		06/14/1969	N	P	O	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	GIBSON HOME HEALTH	157445	21780		10/19/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2013	09/30/2014	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.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)			22.01
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

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

		Urban/Rural S 1.00	Date of Geogr 2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 2/19/2015 8:48 am

		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	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		Program Name	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 2/19/2015 8:48 am

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
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
	Teaching Hospitals that Claim Residents in Non-Provider Settings					
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 Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	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.				
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	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	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 2/19/2015 8:48 am

		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	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME 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 an approved GME 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
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

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		V	XIX	
		1.00	2.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	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.	0			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151319	Period: From 10/01/2013 To 09/30/2014	Worksheet S-2 Part I Date/Time Prepared: 2/19/2015 8:48 am

		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	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2013	09/30/2014	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 2/19/2015 8:48 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C	03/01/2011	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	01/02/2015	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: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 2/19/2015 8:48 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RICH	FERRIELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLIANT MANAGEMENT SERVICES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923832	RFERRIELL@ALLIANTMANAGEMENT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 2/19/2015 8:48 am

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	01/02/2015			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part I Date/Time Prepared: 2/19/2015 8:48 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	20	7,300	38,424.00	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)		20	7,300	38,424.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	5	1,825	5,208.00	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						13.00
14.00	Total (see instructions)		25	9,125	43,632.00	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	44.00	45	16,425		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		70				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: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 2/19/2015 8:48 am

	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)	1,009	94	1,601			1.00
2.00	HMO and other (see instructions)	12	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	561	0	561			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		99	99			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,570	193	2,261			7.00
8.00	INTENSIVE CARE UNIT	151	0	217			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)	1,721	193	2,478	0.00	269.88	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	793	8,856	14,654	0.00	20.94	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	724	151	4,536	0.00	5.60	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	296.42	27.00
28.00	Observation Bed Days		0	426			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: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part I Date/Time Prepared: 2/19/2015 8:48 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
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	313	28	490	1.00
2.00	HMO and other (see instructions)			2	0		2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	313	28	490	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	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part IV Date/Time Prepared: 2/19/2015 8:48 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	235,430	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	2,312,341	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	234,286	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,035,392	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	9,115	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3,826,564	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 151319 | Component CCN: 157445 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-4 | Date/Time Prepared: 2/19/2015 8:48 am

Home Health Agency I | PPS

					1.00		
0.00	County				GIBSON		0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	81.00	0.00	106.00	187.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		0.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			0.00	0.00	0.00	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			21780			20.00
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	863	28	22	24	937	21.00
22.00	Skilled Nursing Visit Charges	100,772	3,493	1,811	2,717	108,793	22.00
23.00	Physical Therapy Visits	678	0	2	7	687	23.00
24.00	Physical Therapy Visit Charges	88,779	0	263	922	89,964	24.00
25.00	Occupational Therapy Visits	180	0	2	4	186	25.00
26.00	Occupational Therapy Visit Charges	23,446	0	263	527	24,236	26.00
27.00	Speech Pathology Visits	1	0	0	0	1	27.00
28.00	Speech Pathology Visit Charges	132	0	0	0	132	28.00
29.00	Medical Social Service Visits	2	0	0	0	2	29.00
30.00	Medical Social Service Visit Charges	351	0	0	0	351	30.00
31.00	Home Health Aide Visits	322	17	0	2	341	31.00
32.00	Home Health Aide Visit Charges	23,017	1,230	0	145	24,392	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,046	45	26	37	2,154	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	236,497	4,723	2,337	4,311	247,868	35.00
36.00	Total Number of Episodes (standard/non outlier)	94		8	3	105	36.00
37.00	Total Number of Outlier Episodes		1		0	1	37.00
38.00	Total Non-Routine Medical Supply Charges	827	2	0	2	831	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-7 | Date/Time Prepared: 2/19/2015 8:48 am

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	12/16/2003	2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	28	0	28	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	22	0	22	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	39	0	39	15.00
16.00		RVB	96	0	96	16.00
17.00		RVA	98	0	98	17.00
18.00		RHC	69	0	69	18.00
19.00		RHB	139	0	139	19.00
20.00		RHA	95	0	95	20.00
21.00		RMC	27	0	27	21.00
22.00		RMB	21	0	21	22.00
23.00		RMA	7	0	7	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	1	0	1	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	14	0	14	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	6	0	6	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	0	0	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	4	0	4	47.00
48.00		CD1	7	0	7	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	11	0	11	50.00
51.00		CB2	7	0	7	51.00
52.00		CB1	17	0	17	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	70	0	70	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-7 | Date/Time Prepared: 2/19/2015 8:48 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	7	0	7	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	7	0	7	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	1	0	1	199.00
200.00	TOTAL		793	0	793	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	21780	21780	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	1,598,071			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-10 | Date/Time Prepared: 2/19/2015 8:48 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.421212	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,884,230	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	6,738,123	6.00
7.00	Medicaid cost (line 1 times line 6)	2,838,178	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)	953,948	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)	953,948	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	269,310	1,573,208	1,842,518	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	113,437	662,654	776,091	21.00
22.00	Partial payment by patients approved for charity care	39,330	19,592	58,922	22.00
23.00	Cost of charity care (line 21 minus line 22)	74,107	643,062	717,169	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,651,059	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	100,360	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	3,550,699	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,495,597	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,212,766	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,166,714	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A | Date/Time Prepared: 2/19/2015 8:48 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,431,400	1,431,400	-538,539	892,861	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	1,276,910	1,276,910	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	149,115	385,511	534,626	162,452	697,078	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,824,703	4,085,049	5,909,752	11,415	5,921,167	5.00
7.00	00700	OPERATION OF PLANT	331,083	956,073	1,287,156	-11,636	1,275,520	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	45,200	64,024	109,224	-701	108,523	8.00
9.00	00900	HOUSEKEEPING	304,786	180,272	485,058	-3,807	481,251	9.00
10.00	01000	DIETARY	416,959	401,738	818,697	-416,487	402,210	10.00
11.00	01100	CAFETERIA	0	0	0	412,405	412,405	11.00
13.00	01300	NURSING ADMINISTRATION	148,212	29,026	177,238	0	177,238	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	232,073	138,984	371,057	-1,317	369,740	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,102,860	525,882	1,628,742	-80,801	1,547,941	30.00
31.00	03100	INTENSIVE CARE UNIT	177,589	47,717	225,306	-6,074	219,232	31.00
44.00	04400	SKILLED NURSING FACILITY	835,070	309,869	1,144,939	-10,170	1,134,769	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	700,855	1,410,531	2,111,386	-428,209	1,683,177	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	694,023	728,139	1,422,162	-59,606	1,362,556	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	120,824	120,824	0	120,824	54.03
60.00	06000	LABORATORY	687,365	948,133	1,635,498	-30,628	1,604,870	60.00
65.00	06500	RESPIRATORY THERAPY	357,512	340,469	697,981	-40,576	657,405	65.00
66.00	06600	PHYSICAL THERAPY	626,993	255,979	882,972	-64,341	818,631	66.00
67.00	06700	OCCUPATIONAL THERAPY	237,356	52,740	290,096	-852	289,244	67.00
68.00	06800	SPEECH PATHOLOGY	126,798	54,103	180,901	-1,295	179,606	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	-6,912	-6,912	77,024	70,112	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	370,099	370,099	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	163,342	1,157,807	1,321,149	-46,268	1,274,881	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	100,211	108,754	208,965	-6,950	202,015	90.00
90.01	09001	DIABETES	36,763	20,446	57,209	-127	57,082	90.01
90.02	09002	OP PSYCH	62,338	96,646	158,984	-450	158,534	90.02
91.00	09100	EMERGENCY	722,137	614,812	1,336,949	-22,271	1,314,678	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	285,272	137,184	422,456	-2,856	419,600	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		266,949	266,949	-266,949	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,368,615	14,862,149	25,230,764	269,395	25,500,159	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	4,197,679	2,765,441	6,963,120	-269,394	6,693,726	194.00
194.01	07951	FOUNDATION	42,082	4,595	46,677	-1	46,676	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	430,565	141,814	572,379	0	572,379	194.03
200.00		TOTAL (SUM OF LINES 118-199)	15,038,941	17,773,999	32,812,940	0	32,812,940	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A | Date/Time Prepared: 2/19/2015 8:48 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-17,867	874,994		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-172,964	1,103,946		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	102,062	799,140		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,211,383	4,709,784		5.00
7.00	00700	OPERATION OF PLANT	-9,686	1,265,834		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	108,523		8.00
9.00	00900	HOUSEKEEPING	0	481,251		9.00
10.00	01000	DIETARY	0	402,210		10.00
11.00	01100	CAFETERIA	-169,110	243,295		11.00
13.00	01300	NURSING ADMINISTRATION	0	177,238		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-9,875	359,865		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-40,774	1,507,167		30.00
31.00	03100	INTENSIVE CARE UNIT	0	219,232		31.00
44.00	04400	SKILLED NURSING FACILITY	0	1,134,769		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-325,000	1,358,177		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,362,556		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	120,824		54.03
60.00	06000	LABORATORY	-30,983	1,573,887		60.00
65.00	06500	RESPIRATORY THERAPY	-25,637	631,768		65.00
66.00	06600	PHYSICAL THERAPY	0	818,631		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	289,244		67.00
68.00	06800	SPEECH PATHOLOGY	0	179,606		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	70,112		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	370,099		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,274,881		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	202,015		90.00
90.01	09001	DIABETES	0	57,082		90.01
90.02	09002	OP PSYCH	-74,338	84,196		90.02
91.00	09100	EMERGENCY	0	1,314,678		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	CARDIAC REHAB	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	419,600		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,985,555	23,514,604		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	MOB	0	6,693,726		194.00
194.01	07951	FOUNDATION	0	46,676		194.01
194.02	07952	ASC	0	0		194.02
194.03	07953	SNF - PERRY CO.	0	572,379		194.03
200.00		TOTAL (SUM OF LINES 118-199)	-1,985,555	30,827,385		200.00

RECLASSIFICATIONS | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-6 | Date/Time Prepared: 2/19/2015 8:48 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INSURANCE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	25,333		1.00
	TOTALS		0	25,333		
	B - DEPRECIATION					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	496,993		1.00
	TOTALS		0	496,993		
	D - CAFETERIA					
1.00	CAFETERIA	11.00	210,036	202,369		1.00
	TOTALS		210,036	202,369		
	E - MED SUPPLY CHG PTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	77,024		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	370,099		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
	TOTALS		0	447,123		
	F - RENTAL EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	474,468		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
24.00		0.00	0	0		24.00
27.00		0.00	0	0		27.00
	TOTALS		0	474,468		
	H - BUSINESS HEALTH SER					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	38,030	27,598		1.00
	TOTALS		38,030	27,598		
	I - INTEREST					
1.00		0.00	0	0		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	263,903		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	3,046		3.00
	TOTALS		0	266,949		
	J - PROPERTY TAX					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	16,213		1.00
	TOTALS		0	16,213		
	K - QUALITY SERVICES					
1.00	ADMINISTRATIVE & GENERAL	5.00	32,823	23,319		1.00
	TOTALS		32,823	23,319		
	L - HEALTH INSURANCE					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	96,824		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00

RECLASSIFICATIONS | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-6 | Date/Time Prepared: 2/19/2015 8:48 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
13.00		0.00	0	0		13.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
	TOTALS		0	96,824		
500.00	Grand Total: Increases		280,889	2,077,189		500.00

RECLASSIFICATIONS | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-6 | Date/Time Prepared: 2/19/2015 8:48 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INSURANCE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	25,333	9		1.00
	TOTALS		0	25,333			
	B - DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	496,993	9		1.00
	TOTALS		0	496,993			
	D - CAFETERIA						
1.00	DIETARY	10.00	210,036	202,369	0		1.00
	TOTALS		210,036	202,369			
	E - MED SUPPLY CHG PTS						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	32	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	3,644	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	321	0		5.00
6.00	SKILLED NURSING FACILITY	44.00	0	722	0		6.00
7.00	OPERATING ROOM	50.00	0	322,954	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	935	0		8.00
10.00	LABORATORY	60.00	0	1,658	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	17,315	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	3,721	0		12.00
13.00	DRUGS CHARGED TO PATIENTS	73.00	0	66	0		13.00
14.00	EMERGENCY	91.00	0	5,479	0		14.00
15.00	HOME HEALTH AGENCY	101.00	0	484	0		15.00
16.00	MOB	194.00	0	89,792	0		16.00
	TOTALS		0	447,123			
	F - RENTAL EXPENSE						
1.00		0.00	0	0	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	31,843	0		2.00
3.00	OPERATION OF PLANT	7.00	0	8,647	0		3.00
9.00	ADULTS & PEDIATRICS	30.00	0	12,392	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	5,217	0		10.00
12.00	OPERATING ROOM	50.00	0	101,649	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	53,424	0		13.00
15.00	LABORATORY	60.00	0	25,258	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	21,924	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	57,678	0		17.00
21.00	DRUGS CHARGED TO PATIENTS	73.00	0	45,408	0		21.00
22.00	CLINIC	90.00	0	5,434	0		22.00
24.00	EMERGENCY	91.00	0	10,435	0		24.00
27.00	MOB	194.00	0	95,159	0		27.00
	TOTALS		0	474,468			
	H - BUSINESS HEALTH SER						
1.00	MOB	194.00	38,030	27,598	0		1.00
	TOTALS		38,030	27,598			
	I - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	266,949	0		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	266,949			
	J - PROPERTY TAX						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	16,213	9		1.00
	TOTALS		0	16,213			
	K - QUALITY SERVICES						
1.00	ADULTS & PEDIATRICS	30.00	32,823	23,319	0		1.00
	TOTALS		32,823	23,319			
	L - HEALTH INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	15,898	0		1.00
2.00	OPERATION OF PLANT	7.00	0	2,989	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	701	0		3.00
4.00	HOUSEKEEPING	9.00	0	3,807	0		4.00
5.00	DIETARY	10.00	0	4,082	0		5.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,317	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	8,623	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	536	0		10.00
11.00	SKILLED NURSING FACILITY	44.00	0	9,448	0		11.00
12.00	OPERATING ROOM	50.00	0	3,606	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,247	0		13.00
15.00	LABORATORY	60.00	0	3,712	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	1,337	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	2,942	0		17.00

RECLASSIFICATIONS | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-6 | Date/Time Prepared: 2/19/2015 8:48 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
18.00	OCCUPATIONAL THERAPY	67.00	0	852	0		18.00
19.00	SPEECH PATHOLOGY	68.00	0	1,295	0		19.00
22.00	DRUGS CHARGED TO PATIENTS	73.00	0	794	0		22.00
23.00	CLINIC	90.00	0	1,516	0		23.00
24.00	DIABETES	90.01	0	127	0		24.00
25.00	OP PSYCH	90.02	0	450	0		25.00
26.00	EMERGENCY	91.00	0	6,357	0		26.00
28.00	HOME HEALTH AGENCY	101.00	0	2,372	0		28.00
29.00	FOUNDATION	194.01	0	1	0		29.00
30.00	MOB	194.00	0	18,815	0		30.00
	TOTALS		0	96,824			
500.00	Grand Total: Decreases		280,889	2,077,189			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-7 Part I | Date/Time Prepared: 2/19/2015 8:48 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	660,012	19,500	0	19,500	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	19,083,961	248,089	0	248,089	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	12,688,012	885,298	0	885,298	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,431,985	1,152,887	0	1,152,887	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	32,431,985	1,152,887	0	1,152,887	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	679,512	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	19,332,050	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	13,573,310	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	33,584,872	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	33,584,872	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-7 Part II | Date/Time Prepared: 2/19/2015 8:48 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,431,400	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,431,400	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,431,400		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	1,431,400		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-7 Part III Date/Time Prepared: 2/19/2015 8:48 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,245,381	0	1,245,381	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	1,245,381	0	1,245,381	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	874,994	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,276,910	-172,964	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,151,904	-172,964	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	874,994	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,103,946	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,978,940	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8 | Date/Time Prepared: 2/19/2015 8:48 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-172,964	NEW CAP REL COSTS-MVBLE EQUIP	2.00	10	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-9,686	OPERATION OF PLANT	7.00	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	-496,732			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-169,110	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-9,875	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	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	-17,867	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8 | Date/Time Prepared: 2/19/2015 8:48 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	MISC INCOME	B	-27,175	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01			0		0.00	0	33.01
33.02			0		0.00	0	33.02
33.03	ADVERTISING	A	-255,794	ADMINISTRATIVE & GENERAL	5.00	0	33.03
34.00	EMPLOYEE DISCOUNT	A	102,062	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.00
35.00	HAF FEE	A	-928,414	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00			0		0.00	0	36.00
37.00			0		0.00	0	37.00
38.00			0		0.00	0	38.00
39.00			0		0.00	0	39.00
40.00			0		0.00	0	40.00
41.00			0		0.00	0	41.00
42.00			0		0.00	0	42.00
43.00			0		0.00	0	43.00
44.00			0		0.00	0	44.00
45.00			0		0.00	0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,985,555				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: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8-2 | Date/Time Prepared: 2/19/2015 8:48 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	40,774	40,774	0	0	0	1.00
2.00	50.00	OPERATING ROOM	325,000	325,000	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	73,962	25,637	48,325	0	0	3.00
4.00	60.00	LABORATORY	30,983	30,983	0	0	0	4.00
5.00	90.02	OP PSYCH	74,338	74,338	0	0	0	5.00
6.00	91.00	EMERGENCY	249,371	0	249,371	0	0	6.00
7.00	90.01	DIABETES	6,000	0	6,000	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			800,428	496,732	303,696		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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	90.02	OP PSYCH	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	90.01	DIABETES	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	40,774		1.00
2.00	50.00	OPERATING ROOM	0	0	0	325,000		2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	25,637		3.00
4.00	60.00	LABORATORY	0	0	0	30,983		4.00
5.00	90.02	OP PSYCH	0	0	0	74,338		5.00
6.00	91.00	EMERGENCY	0	0	0	0		6.00
7.00	90.01	DIABETES	0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	496,732		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 2/19/2015 8:48 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	874,994	874,994				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,103,946		1,103,946			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	799,140	5,386	6,795	811,321		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,709,784	42,674	53,840	101,473	4,907,771	5.00
7.00	00700	OPERATION OF PLANT	1,265,834	150,278	189,600	18,086	1,623,798	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	108,523	15,565	19,637	2,469	146,194	8.00
9.00	00900	HOUSEKEEPING	481,251	8,785	11,084	16,650	517,770	9.00
10.00	01000	DIETARY	402,210	39,962	50,418	11,304	503,894	10.00
11.00	01100	CAFETERIA	243,295	0	0	11,474	254,769	11.00
13.00	01300	NURSING ADMINISTRATION	177,238	2,635	3,325	8,097	191,295	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	359,865	12,729	16,059	12,678	401,331	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,507,167	78,128	98,571	58,454	1,742,320	30.00
31.00	03100	INTENSIVE CARE UNIT	219,232	18,486	23,324	9,701	270,743	31.00
44.00	04400	SKILLED NURSING FACILITY	1,134,769	60,702	76,585	45,618	1,317,674	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,358,177	48,737	61,490	38,286	1,506,690	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,362,556	33,383	42,118	37,913	1,475,970	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	120,824	4,010	5,060	0	129,894	54.03
60.00	06000	LABORATORY	1,573,887	14,610	18,432	37,549	1,644,478	60.00
65.00	06500	RESPIRATORY THERAPY	631,768	15,393	19,420	19,530	686,111	65.00
66.00	06600	PHYSICAL THERAPY	818,631	26,842	33,865	34,251	913,589	66.00
67.00	06700	OCCUPATIONAL THERAPY	289,244	7,811	9,855	12,966	319,876	67.00
68.00	06800	SPEECH PATHOLOGY	179,606	592	747	6,927	187,872	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	70,112	34,271	43,238	0	147,621	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	370,099	0	0	0	370,099	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,274,881	9,663	12,192	8,923	1,305,659	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	202,015	15,402	19,432	5,474	242,323	90.00
90.01	09001	DIABETES	57,082	13,349	16,842	2,008	89,281	90.01
90.02	09002	OP PSYCH	84,196	1,919	2,422	3,405	91,942	90.02
91.00	09100	EMERGENCY	1,314,678	84,497	106,607	39,449	1,545,231	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	419,600	4,822	6,084	15,584	446,090	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,514,604	750,631	947,042	558,269	22,980,285	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	6,693,726	81,508	102,836	227,232	7,105,302	194.00
194.01	07951	FOUNDATION	46,676	12,499	15,770	2,299	77,244	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	572,379	30,356	38,298	23,521	664,554	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	30,827,385	874,994	1,103,946	811,321	30,827,385	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 2/19/2015 8:48 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,907,771					5.00
7.00	00700	OPERATION OF PLANT	307,460	1,931,258				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	27,681	44,423	218,298			8.00
9.00	00900	HOUSEKEEPING	98,038	25,073	9,578	650,459		9.00
10.00	01000	DIETARY	95,410	114,055	3,189	39,849	756,397	10.00
11.00	01100	CAFETERIA	48,239	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	36,221	7,522	0	2,628	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	75,990	36,329	0	12,692	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	329,901	222,987	65,688	77,907	210,186	30.00
31.00	03100	INTENSIVE CARE UNIT	51,264	52,763	1,800	18,434	0	31.00
44.00	04400	SKILLED NURSING FACILITY	249,496	173,250	53,962	60,530	368,520	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	285,286	139,101	9,302	48,599	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	279,469	95,278	9,452	33,288	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	24,595	11,446	0	3,999	0	54.03
60.00	06000	LABORATORY	311,375	41,698	0	14,568	0	60.00
65.00	06500	RESPIRATORY THERAPY	129,912	43,932	5,072	15,349	0	65.00
66.00	06600	PHYSICAL THERAPY	172,984	76,609	13,555	26,766	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	60,567	22,293	0	7,789	0	67.00
68.00	06800	SPEECH PATHOLOGY	35,573	1,690	0	590	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,951	97,812	0	34,174	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	70,077	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	247,221	27,580	0	9,636	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	45,883	43,960	0	15,359	0	90.00
90.01	09001	DIABETES	16,905	38,100	0	13,311	0	90.01
90.02	09002	OP PSYCH	17,409	5,478	0	1,914	0	90.02
91.00	09100	EMERGENCY	292,583	241,167	19,719	84,257	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	84,465	13,763	0	4,808	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,421,955	1,576,309	191,317	526,447	578,706	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	1,345,359	232,635	0	81,278	0	194.00
194.01	07951	FOUNDATION	14,626	35,675	0	12,464	0	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	125,831	86,639	26,981	30,270	177,691	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,907,771	1,931,258	218,298	650,459	756,397	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 2/19/2015 8:48 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	303,008					11.00
13.00	01300	NURSING ADMINISTRATION	2,079	239,745				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,311	0	541,653			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	48,785	78,478	161,210	2,937,462	0	30.00
31.00	03100	INTENSIVE CARE UNIT	6,470	10,409	2,657	414,540	0	31.00
44.00	04400	SKILLED NURSING FACILITY	43,522	70,012	3,543	2,340,509	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,815	0	57,133	2,062,926	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,687	0	48,718	1,968,862	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	169,934	0	54.03
60.00	06000	LABORATORY	30,866	0	40,746	2,083,731	0	60.00
65.00	06500	RESPIRATORY THERAPY	12,147	0	16,830	909,353	0	65.00
66.00	06600	PHYSICAL THERAPY	24,248	0	73,077	1,300,828	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,370	0	0	417,895	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,515	0	0	229,240	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,930	0	0	309,488	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	440,176	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,507	0	0	1,594,603	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,389	0	443	352,357	0	90.00
90.01	09001	DIABETES	2,076	3,339	0	163,012	0	90.01
90.02	09002	OP PSYCH	2,427	0	0	119,170	0	90.02
91.00	09100	EMERGENCY	26,421	42,501	136,853	2,388,732	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	549,126	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	279,565	204,739	541,210	20,751,944	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	0	0	443	8,765,017	0	194.00
194.01	07951	FOUNDATION	1,682	0	0	141,691	0	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	21,761	35,006	0	1,168,733	0	194.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	303,008	239,745	541,653	30,827,385	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 2/19/2015 8:48 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	2,937,462		30.00
31.00	03100	INTENSIVE CARE UNIT	414,540		31.00
44.00	04400	SKILLED NURSING FACILITY	2,340,509		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	2,062,926		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,968,862		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	169,934		54.03
60.00	06000	LABORATORY	2,083,731		60.00
65.00	06500	RESPIRATORY THERAPY	909,353		65.00
66.00	06600	PHYSICAL THERAPY	1,300,828		66.00
67.00	06700	OCCUPATIONAL THERAPY	417,895		67.00
68.00	06800	SPEECH PATHOLOGY	229,240		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	309,488		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	440,176		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,594,603		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	352,357		90.00
90.01	09001	DIABETES	163,012		90.01
90.02	09002	OP PSYCH	119,170		90.02
91.00	09100	EMERGENCY	2,388,732		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04040	CARDIAC REHAB	0		93.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	549,126		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,751,944		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	MOB	8,765,017		194.00
194.01	07951	FOUNDATION	141,691		194.01
194.02	07952	ASC	0		194.02
194.03	07953	SNF - PERRY CO.	1,168,733		194.03
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	30,827,385		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/19/2015 8:48 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,386	6,795	12,181	12,181	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	42,674	53,840	96,514	1,523	5.00
7.00	00700	OPERATION OF PLANT	0	150,278	189,600	339,878	271	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,565	19,637	35,202	37	8.00
9.00	00900	HOUSEKEEPING	0	8,785	11,084	19,869	250	9.00
10.00	01000	DIETARY	0	39,962	50,418	90,380	170	10.00
11.00	01100	CAFETERIA	0	0	0	0	172	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,635	3,325	5,960	122	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,729	16,059	28,788	190	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	78,128	98,571	176,699	877	30.00
31.00	03100	INTENSIVE CARE UNIT	0	18,486	23,324	41,810	146	31.00
44.00	04400	SKILLED NURSING FACILITY	0	60,702	76,585	137,287	685	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	48,737	61,490	110,227	575	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	33,383	42,118	75,501	569	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	4,010	5,060	9,070	0	54.03
60.00	06000	LABORATORY	0	14,610	18,432	33,042	564	60.00
65.00	06500	RESPIRATORY THERAPY	0	15,393	19,420	34,813	293	65.00
66.00	06600	PHYSICAL THERAPY	0	26,842	33,865	60,707	514	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,811	9,855	17,666	195	67.00
68.00	06800	SPEECH PATHOLOGY	0	592	747	1,339	104	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	34,271	43,238	77,509	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,663	12,192	21,855	134	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	15,402	19,432	34,834	82	90.00
90.01	09001	DIABETES	0	13,349	16,842	30,191	30	90.01
90.02	09002	OP PSYCH	0	1,919	2,422	4,341	51	90.02
91.00	09100	EMERGENCY	0	84,497	106,607	191,104	592	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	4,822	6,084	10,906	234	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	750,631	947,042	1,697,673	8,380	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	0	81,508	102,836	184,344	3,413	194.00
194.01	07951	FOUNDATION	0	12,499	15,770	28,269	35	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	0	30,356	38,298	68,654	353	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	874,994	1,103,946	1,978,940	12,181	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/19/2015 8:48 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	98,037					5.00
7.00	00700	OPERATION OF PLANT	6,141	346,290				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	553	7,965	43,757			8.00
9.00	00900	HOUSEKEEPING	1,958	4,496	1,920	28,493		9.00
10.00	01000	DIETARY	1,906	20,451	639	1,746	115,292	10.00
11.00	01100	CAFETERIA	964	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	723	1,349	0	115	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,518	6,514	0	556	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,589	39,983	13,167	3,413	32,037	30.00
31.00	03100	INTENSIVE CARE UNIT	1,024	9,461	361	807	0	31.00
44.00	04400	SKILLED NURSING FACILITY	4,983	31,065	10,816	2,651	56,171	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,698	24,942	1,864	2,129	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,582	17,084	1,895	1,458	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	491	2,052	0	175	0	54.03
60.00	06000	LABORATORY	6,219	7,477	0	638	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,595	7,877	1,017	672	0	65.00
66.00	06600	PHYSICAL THERAPY	3,455	13,737	2,717	1,172	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,210	3,997	0	341	0	67.00
68.00	06800	SPEECH PATHOLOGY	711	303	0	26	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	558	17,539	0	1,497	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,400	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,938	4,945	0	422	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	916	7,882	0	673	0	90.00
90.01	09001	DIABETES	338	6,832	0	583	0	90.01
90.02	09002	OP PSYCH	348	982	0	84	0	90.02
91.00	09100	EMERGENCY	5,844	43,244	3,953	3,692	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,687	2,468	0	211	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	68,349	282,645	38,349	23,061	88,208	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	26,883	41,713	0	3,560	0	194.00
194.01	07951	FOUNDATION	292	6,397	0	546	0	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	2,513	15,535	5,408	1,326	27,084	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	98,037	346,290	43,757	28,493	115,292	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/19/2015 8:48 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,136					11.00
13.00	01300	NURSING ADMINISTRATION	8	8,277				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	57	0	37,623			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	183	2,710	11,197	286,855	0	30.00
31.00	03100	INTENSIVE CARE UNIT	24	359	185	54,177	0	31.00
44.00	04400	SKILLED NURSING FACILITY	163	2,417	246	246,484	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	63	0	3,968	149,466	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	100	0	3,384	105,573	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	11,788	0	54.03
60.00	06000	LABORATORY	116	0	2,830	50,886	0	60.00
65.00	06500	RESPIRATORY THERAPY	46	0	1,169	48,482	0	65.00
66.00	06600	PHYSICAL THERAPY	91	0	5,076	87,469	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	28	0	0	23,437	0	67.00
68.00	06800	SPEECH PATHOLOGY	13	0	0	2,496	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7	0	0	97,110	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,400	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17	0	0	32,311	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	16	0	31	44,434	0	90.00
90.01	09001	DIABETES	8	115	0	38,097	0	90.01
90.02	09002	OP PSYCH	9	0	0	5,815	0	90.02
91.00	09100	EMERGENCY	99	1,467	9,506	259,501	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	15,506	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,048	7,068	37,592	1,561,287	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	0	0	31	259,944	0	194.00
194.01	07951	FOUNDATION	6	0	0	35,545	0	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	82	1,209	0	122,164	0	194.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,136	8,277	37,623	1,978,940	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/19/2015 8:48 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	286,855		30.00
31.00	03100	INTENSIVE CARE UNIT	54,177		31.00
44.00	04400	SKILLED NURSING FACILITY	246,484		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	149,466		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	105,573		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	11,788		54.03
60.00	06000	LABORATORY	50,886		60.00
65.00	06500	RESPIRATORY THERAPY	48,482		65.00
66.00	06600	PHYSICAL THERAPY	87,469		66.00
67.00	06700	OCCUPATIONAL THERAPY	23,437		67.00
68.00	06800	SPEECH PATHOLOGY	2,496		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	97,110		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,400		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,311		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	44,434		90.00
90.01	09001	DIABETES	38,097		90.01
90.02	09002	OP PSYCH	5,815		90.02
91.00	09100	EMERGENCY	259,501		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04040	CARDIAC REHAB	0		93.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	15,506		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,561,287		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	MOB	259,944		194.00
194.01	07951	FOUNDATION	35,545		194.01
194.02	07952	ASC	0		194.02
194.03	07953	SNF - PERRY CO.	122,164		194.03
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	1,978,940		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/19/2015 8:48 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	91,634					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		91,634				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	564	564	14,851,796			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,469	4,469	1,857,526	-4,907,771	25,919,614	5.00
7.00	00700	OPERATION OF PLANT	15,738	15,738	331,083	0	1,623,798	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,630	1,630	45,200	0	146,194	8.00
9.00	00900	HOUSEKEEPING	920	920	304,786	0	517,770	9.00
10.00	01000	DIETARY	4,185	4,185	206,923	0	503,894	10.00
11.00	01100	CAFETERIA	0	0	210,036	0	254,769	11.00
13.00	01300	NURSING ADMINISTRATION	276	276	148,212	0	191,295	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,333	1,333	232,073	0	401,331	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,182	8,182	1,070,037	0	1,742,320	30.00
31.00	03100	INTENSIVE CARE UNIT	1,936	1,936	177,589	0	270,743	31.00
44.00	04400	SKILLED NURSING FACILITY	6,357	6,357	835,070	0	1,317,674	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,104	5,104	700,855	0	1,506,690	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,496	3,496	694,023	0	1,475,970	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	420	420	0	0	129,894	54.03
60.00	06000	LABORATORY	1,530	1,530	687,365	0	1,644,478	60.00
65.00	06500	RESPIRATORY THERAPY	1,612	1,612	357,512	0	686,111	65.00
66.00	06600	PHYSICAL THERAPY	2,811	2,811	626,993	0	913,589	66.00
67.00	06700	OCCUPATIONAL THERAPY	818	818	237,356	0	319,876	67.00
68.00	06800	SPEECH PATHOLOGY	62	62	126,798	0	187,872	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,589	3,589	0	0	147,621	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	370,099	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,012	1,012	163,342	0	1,305,659	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,613	1,613	100,211	0	242,323	90.00
90.01	09001	DIABETES	1,398	1,398	36,763	0	89,281	90.01
90.02	09002	OP PSYCH	201	201	62,338	0	91,942	90.02
91.00	09100	EMERGENCY	8,849	8,849	722,137	0	1,545,231	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	505	505	285,272	0	446,090	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	78,610	78,610	10,219,500	-4,907,771	18,072,514	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	8,536	8,536	4,159,649	0	7,105,302	194.00
194.01	07951	FOUNDATION	1,309	1,309	42,082	0	77,244	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	3,179	3,179	430,565	0	664,554	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)	874,994	1,103,946	811,321		4,907,771	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.548792	12.047341	0.054628		0.189346	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			12,181		98,037	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000820		0.003782	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/19/2015 8:48 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	70,863					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,630	632,368				8.00
9.00	00900	HOUSEKEEPING	920	27,746	68,313			9.00
10.00	01000	DIETARY	4,185	9,239	4,185	63,384		10.00
11.00	01100	CAFETERIA	0	0	0	0	303,172	11.00
13.00	01300	NURSING ADMINISTRATION	276	0	276	0	2,080	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,333	0	1,333	0	15,319	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,182	190,283	8,182	17,613	48,812	30.00
31.00	03100	INTENSIVE CARE UNIT	1,936	5,213	1,936	0	6,474	31.00
44.00	04400	SKILLED NURSING FACILITY	6,357	156,319	6,357	30,881	43,546	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,104	26,945	5,104	0	16,824	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,496	27,382	3,496	0	26,701	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	420	0	420	0	0	54.03
60.00	06000	LABORATORY	1,530	0	1,530	0	30,883	60.00
65.00	06500	RESPIRATORY THERAPY	1,612	14,692	1,612	0	12,154	65.00
66.00	06600	PHYSICAL THERAPY	2,811	39,267	2,811	0	24,261	66.00
67.00	06700	OCCUPATIONAL THERAPY	818	0	818	0	7,374	67.00
68.00	06800	SPEECH PATHOLOGY	62	0	62	0	3,517	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,589	0	3,589	0	1,931	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,012	0	1,012	0	4,509	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,613	0	1,613	0	4,391	90.00
90.01	09001	DIABETES	1,398	0	1,398	0	2,077	90.01
90.02	09002	OP PSYCH	201	0	201	0	2,428	90.02
91.00	09100	EMERGENCY	8,849	57,123	8,849	0	26,435	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	505	0	505	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	57,839	554,209	55,289	48,494	279,716	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	8,536	0	8,536	0	0	194.00
194.01	07951	FOUNDATION	1,309	0	1,309	0	1,683	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	3,179	78,159	3,179	14,890	21,773	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)	1,931,258	218,298	650,459	756,397	303,008	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.253404	0.345207	9.521745	11.933564	0.999459	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	346,290	43,757	28,493	115,292	1,136	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.886753	0.069195	0.417095	1.818945	0.003747	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/19/2015 8:48 am

		Cost Center Description	NURSING ADMINISTRATION (NRSE FTE'S)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	16.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION	149,117			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,223		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	48,812	364		30.00
31.00	03100	INTENSIVE CARE UNIT	6,474	6		31.00
44.00	04400	SKILLED NURSING FACILITY	43,546	8		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	129		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	110		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0		54.03
60.00	06000	LABORATORY	0	92		60.00
65.00	06500	RESPIRATORY THERAPY	0	38		65.00
66.00	06600	PHYSICAL THERAPY	0	165		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	1		90.00
90.01	09001	DIABETES	2,077	0		90.01
90.02	09002	OP PSYCH	0	0		90.02
91.00	09100	EMERGENCY	26,435	309		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	CARDIAC REHAB	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	127,344	1,222		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	MOB	0	1		194.00
194.01	07951	FOUNDATION	0	0		194.01
194.02	07952	ASC	0	0		194.02
194.03	07953	SNF - PERRY CO.	21,773	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)	239,745	541,653		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.607764	442.888798		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	8,277	37,623		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.055507	30.762878		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/19/2015 8:48 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,937,462		2,937,462	0	2,937,462	30.00
31.00	03100	INTENSIVE CARE UNIT	414,540		414,540	0	414,540	31.00
44.00	04400	SKILLED NURSING FACILITY	2,340,509		2,340,509	0	2,340,509	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,062,926		2,062,926	0	2,062,926	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,968,862		1,968,862	0	1,968,862	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	169,934		169,934	0	169,934	54.03
60.00	06000	LABORATORY	2,083,731		2,083,731	0	2,083,731	60.00
65.00	06500	RESPIRATORY THERAPY	909,353	0	909,353	0	909,353	65.00
66.00	06600	PHYSICAL THERAPY	1,300,828	0	1,300,828	0	1,300,828	66.00
67.00	06700	OCCUPATIONAL THERAPY	417,895	0	417,895	0	417,895	67.00
68.00	06800	SPEECH PATHOLOGY	229,240	0	229,240	0	229,240	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	309,488		309,488	0	309,488	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	440,176		440,176	0	440,176	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,594,603		1,594,603	0	1,594,603	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	352,357		352,357	0	352,357	90.00
90.01	09001	DIABETES	163,012		163,012	0	163,012	90.01
90.02	09002	OP PSYCH	119,170		119,170	0	119,170	90.02
91.00	09100	EMERGENCY	2,388,732		2,388,732	0	2,388,732	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	480,571		480,571		480,571	92.00
93.00	04040	CARDIAC REHAB	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	549,126		549,126		549,126	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	21,232,515	0	21,232,515	0	21,232,515	200.00
201.00		Less Observation Beds	480,571		480,571		480,571	201.00
202.00		Total (see instructions)	20,751,944	0	20,751,944	0	20,751,944	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/19/2015 8:48 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,834,872		1,834,872			30.00
31.00	03100	INTENSIVE CARE UNIT	309,636		309,636			31.00
44.00	04400	SKILLED NURSING FACILITY	1,597,862		1,597,862			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	610,540	4,617,768	5,228,308	0.394569	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	293,978	9,557,727	9,851,705	0.199850	0.000000	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	14,130	322,289	336,419	0.505126	0.000000	54.03
60.00	06000	LABORATORY	980,406	7,207,349	8,187,755	0.254494	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	392,906	1,817,882	2,210,788	0.411325	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	819,115	3,204,942	4,024,057	0.323263	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	325,897	1,262,370	1,588,267	0.263114	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	62,645	691,223	753,868	0.304085	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	698,026	476,591	1,174,617	0.263480	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	458,255	170,338	628,593	0.700256	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	872,560	2,108,237	2,980,797	0.534959	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	38,578	38,578	9.133625	0.000000	90.00
90.01	09001	DIABETES	0	35,790	35,790	4.554680	0.000000	90.01
90.02	09002	OP PSYCH	0	189,206	189,206	0.629843	0.000000	90.02
91.00	09100	EMERGENCY	192,130	7,196,642	7,388,772	0.323292	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	18,094	329,908	348,002	1.380943	0.000000	92.00
93.00	04040	CARDIAC REHAB	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	559,331	559,331			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	9,481,052	39,786,171	49,267,223			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,481,052	39,786,171	49,267,223			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/19/2015 8:48 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000	54.03
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	DIABETES	0.000000	90.01
90.02	09002	OP PSYCH	0.000000	90.02
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
93.00	04040	CARDIAC REHAB	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/19/2015 8:48 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,937,462		2,937,462	0	2,937,462	30.00
31.00	03100	INTENSIVE CARE UNIT	414,540		414,540	0	414,540	31.00
44.00	04400	SKILLED NURSING FACILITY	2,340,509		2,340,509	0	2,340,509	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,062,926		2,062,926	0	2,062,926	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,968,862		1,968,862	0	1,968,862	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	169,934		169,934	0	169,934	54.03
60.00	06000	LABORATORY	2,083,731		2,083,731	0	2,083,731	60.00
65.00	06500	RESPIRATORY THERAPY	909,353	0	909,353	0	909,353	65.00
66.00	06600	PHYSICAL THERAPY	1,300,828	0	1,300,828	0	1,300,828	66.00
67.00	06700	OCCUPATIONAL THERAPY	417,895	0	417,895	0	417,895	67.00
68.00	06800	SPEECH PATHOLOGY	229,240	0	229,240	0	229,240	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	309,488		309,488	0	309,488	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	440,176		440,176	0	440,176	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,594,603		1,594,603	0	1,594,603	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	352,357		352,357	0	352,357	90.00
90.01	09001	DIABETES	163,012		163,012	0	163,012	90.01
90.02	09002	OP PSYCH	119,170		119,170	0	119,170	90.02
91.00	09100	EMERGENCY	2,388,732		2,388,732	0	2,388,732	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	480,571		480,571		480,571	92.00
93.00	04040	CARDIAC REHAB	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	549,126		549,126		549,126	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	21,232,515	0	21,232,515	0	21,232,515	200.00
201.00		Less Observation Beds	480,571		480,571		480,571	201.00
202.00		Total (see instructions)	20,751,944	0	20,751,944	0	20,751,944	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/19/2015 8:48 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,834,872		1,834,872			30.00
31.00	03100	INTENSIVE CARE UNIT	309,636		309,636			31.00
44.00	04400	SKILLED NURSING FACILITY	1,597,862		1,597,862			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	610,540	4,617,768	5,228,308	0.394569	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	293,978	9,557,727	9,851,705	0.199850	0.000000	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	14,130	322,289	336,419	0.505126	0.000000	54.03
60.00	06000	LABORATORY	980,406	7,207,349	8,187,755	0.254494	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	392,906	1,817,882	2,210,788	0.411325	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	819,115	3,204,942	4,024,057	0.323263	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	325,897	1,262,370	1,588,267	0.263114	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	62,645	691,223	753,868	0.304085	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	698,026	476,591	1,174,617	0.263480	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	458,255	170,338	628,593	0.700256	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	872,560	2,108,237	2,980,797	0.534959	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	38,578	38,578	9.133625	0.000000	90.00
90.01	09001	DIABETES	0	35,790	35,790	4.554680	0.000000	90.01
90.02	09002	OP PSYCH	0	189,206	189,206	0.629843	0.000000	90.02
91.00	09100	EMERGENCY	192,130	7,196,642	7,388,772	0.323292	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	18,094	329,908	348,002	1.380943	0.000000	92.00
93.00	04040	CARDIAC REHAB	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	559,331	559,331			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	9,481,052	39,786,171	49,267,223			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,481,052	39,786,171	49,267,223			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/19/2015 8:48 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.394569		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.199850		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.505126		54.03
60.00	06000	LABORATORY	0.254494		60.00
65.00	06500	RESPIRATORY THERAPY	0.411325		65.00
66.00	06600	PHYSICAL THERAPY	0.323263		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.263114		67.00
68.00	06800	SPEECH PATHOLOGY	0.304085		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.263480		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.700256		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.534959		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	9.133625		90.00
90.01	09001	DIABETES	4.554680		90.01
90.02	09002	OP PSYCH	0.629843		90.02
91.00	09100	EMERGENCY	0.323292		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.380943		92.00
93.00	04040	CARDIAC REHAB	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part II Date/Time Prepared: 2/19/2015 8:48 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,062,926	149,466	1,913,460	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,968,862	105,573	1,863,289	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	169,934	11,788	158,146	0	0	54.03
60.00	06000	LABORATORY	2,083,731	50,886	2,032,845	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	909,353	48,482	860,871	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,300,828	87,469	1,213,359	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	417,895	23,437	394,458	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	229,240	2,496	226,744	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	309,488	97,110	212,378	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	440,176	1,400	438,776	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,594,603	32,311	1,562,292	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	352,357	44,434	307,923	0	0	90.00
90.01	09001	DIABETES	163,012	38,097	124,915	0	0	90.01
90.02	09002	OP PSYCH	119,170	5,815	113,355	0	0	90.02
91.00	09100	EMERGENCY	2,388,732	259,501	2,129,231	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	480,571	60,286	420,285	0	0	92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	549,126	15,506	533,620	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	15,540,004	1,034,057	14,505,947	0	0	200.00
201.00		Less Observation Beds	480,571	60,286	420,285	0	0	201.00
202.00		Total (line 200 minus line 201)	15,059,433	973,771	14,085,662	0	0	202.00

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

Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part II Date/Time Prepared: 2/19/2015 8:48 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,062,926	5,228,308	0.394569		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,968,862	9,851,705	0.199850		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	169,934	336,419	0.505126		54.03
60.00	06000	LABORATORY	2,083,731	8,187,755	0.254494		60.00
65.00	06500	RESPIRATORY THERAPY	909,353	2,210,788	0.411325		65.00
66.00	06600	PHYSICAL THERAPY	1,300,828	4,024,057	0.323263		66.00
67.00	06700	OCCUPATIONAL THERAPY	417,895	1,588,267	0.263114		67.00
68.00	06800	SPEECH PATHOLOGY	229,240	753,868	0.304085		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	309,488	1,174,617	0.263480		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	440,176	628,593	0.700256		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,594,603	2,980,797	0.534959		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	352,357	38,578	9.133625		90.00
90.01	09001	DIABETES	163,012	35,790	4.554680		90.01
90.02	09002	OP PSYCH	119,170	189,206	0.629843		90.02
91.00	09100	EMERGENCY	2,388,732	7,388,772	0.323292		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	480,571	348,002	1.380943		92.00
93.00	04040	CARDIAC REHAB	0	0	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	549,126	559,331	0.981755		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	15,540,004	45,524,853			200.00
201.00		Less Observation Beds	480,571	0			201.00
202.00		Total (line 200 minus line 201)	15,059,433	45,524,853			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part II Date/Time Prepared: 2/19/2015 8:48 am

Title XVIII | Hospital | Cost

		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	149,466	5,228,308	0.028588	362,578	10,365	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	105,573	9,851,705	0.010716	157,162	1,684	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	11,788	336,419	0.035040	8,469	297	54.03
60.00	06000	LABORATORY	50,886	8,187,755	0.006215	504,511	3,136	60.00
65.00	06500	RESPIRATORY THERAPY	48,482	2,210,788	0.021930	244,103	5,353	65.00
66.00	06600	PHYSICAL THERAPY	87,469	4,024,057	0.021737	166,995	3,630	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,437	1,588,267	0.014756	52,049	768	67.00
68.00	06800	SPEECH PATHOLOGY	2,496	753,868	0.003311	26,062	86	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	97,110	1,174,617	0.082674	235,995	19,511	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,400	628,593	0.002227	458,255	1,021	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,311	2,980,797	0.010840	351,117	3,806	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	44,434	38,578	1.151796	0	0	90.00
90.01	09001	DIABETES	38,097	35,790	1.064459	0	0	90.01
90.02	09002	OP PSYCH	5,815	189,206	0.030734	0	0	90.02
91.00	09100	EMERGENCY	259,501	7,388,772	0.035121	3,029	106	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	60,286	348,002	0.173235	678	117	92.00
93.00	04040	CARDIAC REHAB	0	0	0.000000	0	0	93.00
200.00		Total (lines 50-199)	1,018,551	44,965,522		2,571,003	49,880	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV | Date/Time Prepared: 2/19/2015 8:48 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.03
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
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 PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	0	0	0	0	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
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: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV Date/Time Prepared: 2/19/2015 8:48 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,228,308	0.000000	0.000000	362,578	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,851,705	0.000000	0.000000	157,162	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	336,419	0.000000	0.000000	8,469	54.03
60.00	06000	LABORATORY	0	8,187,755	0.000000	0.000000	504,511	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,210,788	0.000000	0.000000	244,103	65.00
66.00	06600	PHYSICAL THERAPY	0	4,024,057	0.000000	0.000000	166,995	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,588,267	0.000000	0.000000	52,049	67.00
68.00	06800	SPEECH PATHOLOGY	0	753,868	0.000000	0.000000	26,062	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,174,617	0.000000	0.000000	235,995	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	628,593	0.000000	0.000000	458,255	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,980,797	0.000000	0.000000	351,117	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	38,578	0.000000	0.000000	0	90.00
90.01	09001	DIABETES	0	35,790	0.000000	0.000000	0	90.01
90.02	09002	OP PSYCH	0	189,206	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	7,388,772	0.000000	0.000000	3,029	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	348,002	0.000000	0.000000	678	92.00
93.00	04040	CARDIAC REHAB	0	0	0.000000	0.000000	0	93.00
200.00		Total (lines 50-199)	0	44,965,522			2,571,003	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV | Date/Time Prepared: 2/19/2015 8:48 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0		54.03
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	DIABETES	0	0	0		90.01
90.02	09002	OP PSYCH	0	0	0		90.02
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040	CARDIAC REHAB	0	0	0		93.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V Date/Time Prepared: 2/19/2015 8:48 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.394569	0	1,565,997	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.199850	0	2,679,895	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.505126	0	121,515	0	0	54.03
60.00	06000	LABORATORY	0.254494	0	2,902,440	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.411325	0	469,205	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.323263	0	1,094,637	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.263114	0	228,226	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.304085	0	42,443	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.263480	0	89,390	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.700256	0	141,341	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.534959	0	875,059	1,808	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9.133625	0	32,641	0	0	90.00
90.01	09001	DIABETES	4.554680	0	9,842	0	0	90.01
90.02	09002	OP PSYCH	0.629843	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.323292	0	1,585,864	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.380943	0	133,832	0	0	92.00
93.00	04040	CARDIAC REHAB	0.000000	0	0	0	0	93.00
200.00		Subtotal (see instructions)		0	11,972,327	1,808	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	11,972,327	1,808	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V Date/Time Prepared: 2/19/2015 8:48 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	617,894	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	535,577	0		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	61,380	0		54.03
60.00	06000	LABORATORY	738,654	0		60.00
65.00	06500	RESPIRATORY THERAPY	192,996	0		65.00
66.00	06600	PHYSICAL THERAPY	353,856	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	60,049	0		67.00
68.00	06800	SPEECH PATHOLOGY	12,906	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,552	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	98,975	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	468,121	967		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	298,131	0		90.00
90.01	09001	DIABETES	44,827	0		90.01
90.02	09002	OP PSYCH	0	0		90.02
91.00	09100	EMERGENCY	512,697	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	184,814	0		92.00
93.00	04040	CARDIAC REHAB	0	0		93.00
200.00		Subtotal (see instructions)	4,204,429	967		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	4,204,429	967		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151319 | Component CCN: 15Z319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V Date/Time Prepared: 2/19/2015 8:48 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.394569	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.199850	0	0	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.505126	0	0	0	0	54.03
60.00	06000	LABORATORY	0.254494	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.411325	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.323263	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.263114	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.304085	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.263480	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.700256	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.534959	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9.133625	0	0	0	0	90.00
90.01	09001	DIABETES	4.554680	0	0	0	0	90.01
90.02	09002	OP PSYCH	0.629843	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.323292	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.380943	0	0	0	0	92.00
93.00	04040	CARDIAC REHAB	0.000000	0	0	0	0	93.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151319 | Component CCN: 15Z319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V | Date/Time Prepared: 2/19/2015 8:48 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0		54.03
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	DIABETES	0	0		90.01
90.02	09002	OP PSYCH	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	CARDIAC REHAB	0	0		93.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151319 | Component CCN: 155093 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV | Date/Time Prepared: 2/19/2015 8:48 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.03
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
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 PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	0	0	0	0	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
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: 151319 | Component CCN: 155093 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV | Date/Time Prepared: 2/19/2015 8:48 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,228,308	0.000000	0.000000	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,851,705	0.000000	0.000000	6,608	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	336,419	0.000000	0.000000	0	54.03
60.00	06000	LABORATORY	0	8,187,755	0.000000	0.000000	83,886	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,210,788	0.000000	0.000000	41,456	65.00
66.00	06600	PHYSICAL THERAPY	0	4,024,057	0.000000	0.000000	228,228	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,588,267	0.000000	0.000000	125,381	67.00
68.00	06800	SPEECH PATHOLOGY	0	753,868	0.000000	0.000000	17,645	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,174,617	0.000000	0.000000	10,573	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	628,593	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,980,797	0.000000	0.000000	82,299	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	38,578	0.000000	0.000000	0	90.00
90.01	09001	DIABETES	0	35,790	0.000000	0.000000	0	90.01
90.02	09002	OP PSYCH	0	189,206	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	7,388,772	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	348,002	0.000000	0.000000	0	92.00
93.00	04040	CARDIAC REHAB	0	0	0.000000	0.000000	0	93.00
200.00		Total (lines 50-199)	0	44,965,522			596,076	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151319 | Component CCN: 155093 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV | Date/Time Prepared: 2/19/2015 8:48 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0		54.03
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	DIABETES	0	0	0		90.01
90.02	09002	OP PSYCH	0	0	0		90.02
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040	CARDIAC REHAB	0	0	0		93.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part I Date/Time Prepared: 2/19/2015 8:48 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	286,855	63,554	223,301	2,027	110.16	30.00
31.00	INTENSIVE CARE UNIT	54,177		54,177	217	249.66	31.00
44.00	SKILLED NURSING FACILITY	246,484		246,484	14,654	16.82	44.00
200.00	Total (lines 30-199)	587,516		523,962	16,898		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	94	10,355				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
44.00	SKILLED NURSING FACILITY	8,856	148,958				44.00
200.00	Total (lines 30-199)	8,950	159,313				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part II Date/Time Prepared: 2/19/2015 8:48 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	149,466	5,228,308	0.028588	150,940	4,315	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	105,573	9,851,705	0.010716	4,849	52	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	11,788	336,419	0.035040	0	0	54.03
60.00	06000	LABORATORY	50,886	8,187,755	0.006215	44,264	275	60.00
65.00	06500	RESPIRATORY THERAPY	48,482	2,210,788	0.021930	34,231	751	65.00
66.00	06600	PHYSICAL THERAPY	87,469	4,024,057	0.021737	8,567	186	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,437	1,588,267	0.014756	3,829	57	67.00
68.00	06800	SPEECH PATHOLOGY	2,496	753,868	0.003311	549	2	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	97,110	1,174,617	0.082674	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,400	628,593	0.002227	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,311	2,980,797	0.010840	39,607	429	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	44,434	38,578	1.151796	0	0	90.00
90.01	09001	DIABETES	38,097	35,790	1.064459	0	0	90.01
90.02	09002	OP PSYCH	5,815	189,206	0.030734	0	0	90.02
91.00	09100	EMERGENCY	259,501	7,388,772	0.035121	29,095	1,022	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	60,286	348,002	0.173235	0	0	92.00
93.00	04040	CARDIAC REHAB	0	0	0.000000	0	0	93.00
200.00		Total (lines 50-199)	1,018,551	44,965,522		315,931	7,089	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part III Date/Time Prepared: 2/19/2015 8:48 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,027	0.00	94	0		30.00
31.00	03100	INTENSIVE CARE UNIT	217	0.00	0	0		31.00
44.00	04400	SKILLED NURSING FACILITY	14,654	0.00	8,856	0		44.00
200.00		Total (lines 30-199)	16,898		8,950	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV Date/Time Prepared: 2/19/2015 8:48 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.03
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
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 PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	0	0	0	0	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
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: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV Date/Time Prepared: 2/19/2015 8:48 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,228,308	0.000000	0.000000	150,940	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,851,705	0.000000	0.000000	4,849	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	336,419	0.000000	0.000000	0	54.03
60.00	06000	LABORATORY	0	8,187,755	0.000000	0.000000	44,264	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,210,788	0.000000	0.000000	34,231	65.00
66.00	06600	PHYSICAL THERAPY	0	4,024,057	0.000000	0.000000	8,567	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,588,267	0.000000	0.000000	3,829	67.00
68.00	06800	SPEECH PATHOLOGY	0	753,868	0.000000	0.000000	549	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,174,617	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	628,593	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,980,797	0.000000	0.000000	39,607	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	38,578	0.000000	0.000000	0	90.00
90.01	09001	DIABETES	0	35,790	0.000000	0.000000	0	90.01
90.02	09002	OP PSYCH	0	189,206	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	7,388,772	0.000000	0.000000	29,095	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	348,002	0.000000	0.000000	0	92.00
93.00	04040	CARDIAC REHAB	0	0	0.000000	0.000000	0	93.00
200.00		Total (lines 50-199)	0	44,965,522			315,931	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV Date/Time Prepared: 2/19/2015 8:48 am

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0		54.03
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	DIABETES	0	0	0		90.01
90.02	09002	OP PSYCH	0	0	0		90.02
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040	CARDIAC REHAB	0	0	0		93.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V Date/Time Prepared: 2/19/2015 8:48 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.394569	0	0	492,529	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.199850	0	0	1,136,753	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.505126	0	0	20,807	0	54.03
60.00	06000	LABORATORY	0.254494	0	0	893,666	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.411325	0	0	192,446	0	65.00
66.00	06600	PHYSICAL THERAPY	0.323263	0	0	181,997	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.263114	0	0	121,202	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.304085	0	0	173,951	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.263480	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.700256	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.534959	0	0	147,996	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9.133625	0	0	0	0	90.00
90.01	09001	DIABETES	4.554680	0	0	3,636	0	90.01
90.02	09002	OP PSYCH	0.629843	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.323292	0	0	1,554,177	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.380943	0	0	0	0	92.00
93.00	04040	CARDIAC REHAB	0.000000	0	0	0	0	93.00
200.00		Subtotal (see instructions)		0	0	4,919,160	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	4,919,160	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V Date/Time Prepared: 2/19/2015 8:48 am

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	194,337		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	227,180		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	10,510		54.03
60.00	06000	LABORATORY	0	227,433		60.00
65.00	06500	RESPIRATORY THERAPY	0	79,158		65.00
66.00	06600	PHYSICAL THERAPY	0	58,833		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	31,890		67.00
68.00	06800	SPEECH PATHOLOGY	0	52,896		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	79,172		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	DIABETES	0	16,561		90.01
90.02	09002	OP PSYCH	0	0		90.02
91.00	09100	EMERGENCY	0	502,453		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	CARDIAC REHAB	0	0		93.00
200.00		Subtotal (see instructions)	0	1,480,423		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	1,480,423		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/19/2015 8:48 am

Title XVIII | 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)	2,687	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,027	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)	1,601	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	561	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	99	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)	1,009	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)	561	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	181.25	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	181.25	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,937,462	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)	17,944	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)	650,808	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,286,654	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)	2,286,654	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)	1,128.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,138,253	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,138,253	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/19/2015 8:48 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	414,540	217	1,910.32	151	288,458	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,055,977	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,482,688	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)	632,864	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)	632,864	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)	426	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,128.10	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	480,571	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/19/2015 8:48 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	286,855	2,286,654	0.125447	480,571	60,286	90.00
91.00	Nursing School cost	0	2,286,654	0.000000	480,571	0	91.00
92.00	Allied health cost	0	2,286,654	0.000000	480,571	0	92.00
93.00	All other Medical Education	0	2,286,654	0.000000	480,571	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151319 Component CCN: 155093	Period: From 10/01/2013 To 09/30/2014	Worksheet D-1 Date/Time Prepared: 2/19/2015 8:48 am
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,654	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,654	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)	14,654	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)	793	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	181.25	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	181.25	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,340,509	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)	2,340,509	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)	2,340,509	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151319 | Component CCN: 155093 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/19/2015 8:48 am

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	2,340,509	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	159.72	71.00
72.00	Program routine service cost (line 9 x line 71)	126,658	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	126,658	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	126,658	83.00
84.00	Program inpatient ancillary services (see instructions)	198,667	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	325,325	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151319 | Component CCN: 155093 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/19/2015 8:48 am

Title XVIII | Skilled Nursing Facility | PPS

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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/19/2015 8:48 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,687	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,027	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)	1,601	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	561	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	99	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)	94	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	99	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	181.25	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	181.25	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,937,462	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)	17,944	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)	650,808	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,286,654	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)	2,286,654	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)	1,128.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	106,041	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)	106,041	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/19/2015 8:48 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	414,540	217	1,910.32	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	120,407	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	226,448	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)	10,355	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	7,089	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	17,444	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	209,004	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)	17,944	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)	17,944	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)	426	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,128.10	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	480,571	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/19/2015 8:48 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	286,855	2,286,654	0.125447	480,571	60,286	90.00
91.00	Nursing School cost	0	2,286,654	0.000000	480,571	0	91.00
92.00	Allied health cost	0	2,286,654	0.000000	480,571	0	92.00
93.00	All other Medical Education	0	2,286,654	0.000000	480,571	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151319 Component CCN: 155093	Period: From 10/01/2013 To 09/30/2014	Worksheet D-1 Date/Time Prepared: 2/19/2015 8:48 am
	Title XIX	Skilled Nursing Facility	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)	14,654	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,654	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)	14,654	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)	8,856	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	181.25	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	181.25	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,340,509	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)	2,340,509	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)	2,340,509	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1

Component CCN: 155093 | Date/Time Prepared: 2/19/2015 8:48 am

Title XIX | Skilled Nursing Facility | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	2,340,509	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	159.72	71.00
72.00	Program routine service cost (line 9 x line 71)	1,414,480	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	1,414,480	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	246,484	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	16.82	76.00
77.00	Program capital-related costs (line 9 x line 76)	148,958	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	1,265,522	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	1,265,522	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	148,958	83.00
84.00	Program inpatient ancillary services (see instructions)	0	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	148,958	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151319 | Period: From 10/01/2013 | Worksheet D-1
Component CCN: 155093 | To 09/30/2014 | Date/Time Prepared: 2/19/2015 8:48 am

Title XIX | Skilled Nursing Facility | Cost

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-3 | Date/Time Prepared: 2/19/2015 8:48 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		795,137		30.00
31.00	03100	INTENSIVE CARE UNIT		199,131		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.394569	362,578	143,062	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.199850	157,162	31,409	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.505126	8,469	4,278	54.03
60.00	06000	LABORATORY	0.254494	504,511	128,395	60.00
65.00	06500	RESPIRATORY THERAPY	0.411325	244,103	100,406	65.00
66.00	06600	PHYSICAL THERAPY	0.323263	166,995	53,983	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.263114	52,049	13,695	67.00
68.00	06800	SPEECH PATHOLOGY	0.304085	26,062	7,925	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.263480	235,995	62,180	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.700256	458,255	320,896	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.534959	351,117	187,833	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	9.133625	0	0	90.00
90.01	09001	DIABETES	4.554680	0	0	90.01
90.02	09002	OP PSYCH	0.629843	0	0	90.02
91.00	09100	EMERGENCY	0.323292	3,029	979	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.380943	678	936	92.00
93.00	04040	CARDIAC REHAB	0.000000	0	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		2,571,003	1,055,977	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)		2,571,003		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151319 | Component CCN: 15Z319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-3 | Date/Time Prepared: 2/19/2015 8:48 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.394569	7,654	3,020	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.199850	23,649	4,726	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.505126	0	0	54.03
60.00	06000	LABORATORY	0.254494	107,473	27,351	60.00
65.00	06500	RESPIRATORY THERAPY	0.411325	63,459	26,102	65.00
66.00	06600	PHYSICAL THERAPY	0.323263	170,160	55,006	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.263114	44,703	11,762	67.00
68.00	06800	SPEECH PATHOLOGY	0.304085	5,867	1,784	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.263480	63,353	16,692	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.700256	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.534959	100,364	53,691	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	9.133625	0	0	90.00
90.01	09001	DIABETES	4.554680	0	0	90.01
90.02	09002	OP PSYCH	0.629843	0	0	90.02
91.00	09100	EMERGENCY	0.323292	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.380943	772	1,066	92.00
93.00	04040	CARDIAC REHAB	0.000000	0	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		587,454	201,200	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)		587,454		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151319 | Component CCN: 155093 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-3 | Date/Time Prepared: 2/19/2015 8:48 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.394569	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.199850	6,608	1,321	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.505126	0	0	54.03
60.00	06000	LABORATORY	0.254494	83,886	21,348	60.00
65.00	06500	RESPIRATORY THERAPY	0.411325	41,456	17,052	65.00
66.00	06600	PHYSICAL THERAPY	0.323263	228,228	73,778	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.263114	125,381	32,989	67.00
68.00	06800	SPEECH PATHOLOGY	0.304085	17,645	5,366	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.263480	10,573	2,786	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.700256	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.534959	82,299	44,027	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	9.133625	0	0	90.00
90.01	09001	DIABETES	4.554680	0	0	90.01
90.02	09002	OP PSYCH	0.629843	0	0	90.02
91.00	09100	EMERGENCY	0.323292	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.380943	0	0	92.00
93.00	04040	CARDIAC REHAB	0.000000	0	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		596,076	198,667	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)		596,076		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-3 | Date/Time Prepared: 2/19/2015 8:48 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		106,481		30.00
31.00	03100	INTENSIVE CARE UNIT		17,365		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.394569	150,940	59,556	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.199850	4,849	969	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.505126	0	0	54.03
60.00	06000	LABORATORY	0.254494	44,264	11,265	60.00
65.00	06500	RESPIRATORY THERAPY	0.411325	34,231	14,080	65.00
66.00	06600	PHYSICAL THERAPY	0.323263	8,567	2,769	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.263114	3,829	1,007	67.00
68.00	06800	SPEECH PATHOLOGY	0.304085	549	167	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.263480	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.700256	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.534959	39,607	21,188	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	9.133625	0	0	90.00
90.01	09001	DIABETES	4.554680	0	0	90.01
90.02	09002	OP PSYCH	0.629843	0	0	90.02
91.00	09100	EMERGENCY	0.323292	29,095	9,406	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.380943	0	0	92.00
93.00	04040	CARDIAC REHAB	0.000000	0	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		315,931	120,407	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)		315,931		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151319 | Component CCN: 155093 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-3 | Date/Time Prepared: 2/19/2015 8:48 am

Title XIX | Skilled Nursing Facility | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.394569	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.199850	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.505126	0	0	54.03
60.00	06000	LABORATORY	0.254494	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.411325	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.323263	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.263114	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.304085	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.263480	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.700256	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.534959	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	9.133625	0	0	90.00
90.01	09001	DIABETES	4.554680	0	0	90.01
90.02	09002	OP PSYCH	0.629843	0	0	90.02
91.00	09100	EMERGENCY	0.323292	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.380943	0	0	92.00
93.00	04040	CARDIAC REHAB	0.000000	0	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151319	Period: From 10/01/2013 To 09/30/2014	Worksheet E Part B Date/Time Prepared: 2/19/2015 8:48 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,205,396	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,205,396	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 chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	4,247,450	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	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)	34,939	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,827,108	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	2,385,403	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,385,403	30.00
31.00	Primary payer payments	557	31.00
32.00	Subtotal (line 30 minus line 31)	2,384,846	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)	122,946	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	93,439	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	101,716	36.00
37.00	Subtotal (see instructions)	2,478,285	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,478,285	40.00
40.01	Sequestration adjustment (see instructions)	49,566	40.01
41.00	Interim payments	2,814,281	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-385,562	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §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: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 2/19/2015 8:48 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,795,038		2,723,181	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	09/15/2014	132,100	04/17/2014	91,100	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)		132,100		91,100	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,927,138		2,814,281	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		262,873		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		385,562	6.02
7.00	Total Medicare program liability (see instructions)		2,190,011		2,428,719	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151319 | Component CCN: 15Z319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 2/19/2015 8:48 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		725,150		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	09/15/2014	81,300		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)		81,300		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)		806,450		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		16,143		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		822,593		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151319 | Component CCN: 155093 | Period: From 10/01/2013 To 09/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 2/19/2015 8:48 am

Title XVIII | Skilled Nursing Facility | 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		209,027		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		209,027		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		209,027		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 151319	Period: From 10/01/2013 To 09/30/2014	Worksheet E-1 Part II Date/Time Prepared: 2/19/2015 8:48 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	490	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	1,160	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	12	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	1,818	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	49,267,223	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	1,842,518	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	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)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 151319 Component CCN: 15Z319	Period: From 10/01/2013 To 09/30/2014	Worksheet E-2 Date/Time Prepared: 2/19/2015 8:48 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	639,193	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 6 and 7, line 202 for Part B) (For CAH, see instructions)	203,212	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	561	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	842,405	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	842,405	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	842,405	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	3,024	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	839,381	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	RURAL DEMONSTRATION PROJECT	0		16.50
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	839,381	0	19.00
19.01	Sequestration adjustment (see instructions)	16,788	0	19.01
20.00	Interim payments	806,450	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21	16,143	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151319	Period: From 10/01/2013 To 09/30/2014	Worksheet E-3 Part V Date/Time Prepared: 2/19/2015 8:48 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,482,688	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)	2,482,688	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,507,515	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 physicians' services in a teaching hospital (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)	2,507,515	19.00
20.00	Deductibles (exclude professional component)	278,515	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,229,000	22.00
23.00	Coinsurance	1,216	23.00
24.00	Subtotal (line 22 minus line 23)	2,227,784	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	9,106	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	6,921	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	6,764	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,234,705	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)	2,234,705	30.00
30.01	Sequestration adjustment (see instructions)	44,694	30.01
31.00	Interim payments	1,927,138	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	262,873	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151319 Component CCN: 155093	Period: From 10/01/2013 To 09/30/2014	Worksheet E-3 Part VI Date/Time Prepared: 2/19/2015 8:48 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	274,873	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	274,873	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	61,580	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)	213,293	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14	213,293	15.00
15.01	Sequestration adjustment (see instructions)	4,266	15.01
16.00	Interim payments	209,027	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program line 15 minus 15.01, 16 and 17	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151319	Period: From 10/01/2013 To 09/30/2014	Worksheet E-3 Part VII Date/Time Prepared: 2/19/2015 8:48 am
	Title XIX	Hospital	PPS

		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	0		1.00
2.00	Medical and other services		1,480,423	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	1,480,423	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)	0	1,480,423	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	315,931	4,919,160	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)	315,931	4,919,160	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)	315,931	4,919,160	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	315,931	3,438,737	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 physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	1,480,423	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)	0	1,480,423	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)	0	1,480,423	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	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)	0	1,480,423	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	1,480,423	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)	0	1,480,423	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	1,480,423	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151319 Component CCN: 155093	Period: From 10/01/2013 To 09/30/2014	Worksheet E-3 Part VII Date/Time Prepared: 2/19/2015 8:48 am
	Title XIX	Skilled Nursing Facility	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	148,958		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)	148,958	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)	148,958	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	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)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	148,958	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	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)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	148,958	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	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)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	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)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §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: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G | Date/Time Prepared: 2/19/2015 8:48 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	997,121	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	8,128,252	0	0	0	4.00
5.00	Other receivable	306,293	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,685,432	0	0	0	6.00
7.00	Inventory	667,976	0	0	0	7.00
8.00	Prepaid expenses	132,126	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	5,546,336	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	33,584,872	0	0	0	15.00
16.00	Accumulated depreciation	-21,041,792	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	12,543,080	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	4,853,899	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,853,899	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	22,943,315	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	536,999	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,526,826	0	0	0	38.00
39.00	Payroll taxes payable	3,468	0	0	0	39.00
40.00	Notes and loans payable (short term)	901,132	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,968,425	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	8,792,456	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	8,792,456	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	11,760,881	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	11,182,434				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)	11,182,434	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	22,943,315	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G-1 | Date/Time Prepared: 2/19/2015 8:48 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		11,682,641		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-500,207				2.00
3.00	Total (sum of line 1 and line 2)		11,182,434		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		11,182,434		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		11,182,434		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/19/2015 8:48 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,153,914		2,153,914	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	1,598,071		1,598,071	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,751,985		3,751,985	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	343,493		343,493	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)	343,493		343,493	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,095,478		4,095,478	17.00
18.00	Ancillary services	5,678,333	38,665,896	44,344,229	18.00
19.00	Outpatient services	0	263,573	263,573	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		559,331	559,331	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				26.00
27.00	MOB AND SNF	838,297	966,761	1,805,058	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	10,612,108	40,455,561	51,067,669	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		32,812,940		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	NON OPERATING EXPENSE	3,114,540			37.00
38.00	INDUSTRIAL MEDICINE EXPENSE	3,816,502			38.00
39.00	DR BAD DEBT	322			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		6,931,364		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		25,881,576		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G-3 | Date/Time Prepared: 2/19/2015 8:48 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	51,067,669	1.00
2.00	Less contractual allowances and discounts on patients' accounts	24,881,013	2.00
3.00	Net patient revenues (line 1 minus line 2)	26,186,656	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	25,881,576	4.00
5.00	Net income from service to patients (line 3 minus line 4)	305,080	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 OPERATING REVENUE	473,761	24.00
24.01	NET INDUSTRIAL MEDICINE	209,361	24.01
24.02	NON OPERATING INCOME	571,185	24.02
25.00	Total other income (sum of lines 6-24)	1,254,307	25.00
26.00	Total (line 5 plus line 25)	1,559,387	26.00
27.00	NET NON OPERATING REVENUE	2,059,594	27.00
27.01		0	27.01
27.02		0	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	2,059,594	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-500,207	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151319 | HHA CCN: 157445 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H | Date/Time Prepared: 2/19/2015 8:48 am

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 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	75,843	19,482	30,118	0	24,740	150,183	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	161,529	51,467	0	0	0	212,996	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 Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	47,900	10,893	0	0	0	58,793	11.00
12.00	Supplies (see instructions)	0	0	0	0	484	484	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	285,272	81,842	30,118	0	25,224	422,456	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	-2,856	147,327	0	147,327			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	212,996	0	212,996			6.00
7.00	Physical Therapy	0	0	0	0			7.00
8.00	Occupational Therapy	0	0	0	0			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	58,793	0	58,793			11.00
12.00	Supplies (see instructions)	0	484	0	484			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	-2,856	419,600	0	419,600			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: 151319 | HHA CCN: 157445 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-1 Part I | Date/Time Prepared: 2/19/2015 8:48 am

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	147,327	0	0	0	0	147,327	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	212,996	0	0	0	0	212,996	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 Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	58,793	0	0	0	0	58,793	11.00
12.00	Supplies (see instructions)	484	0	0	0	0	484	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	419,600	0	0	0	0	419,600	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	147,327			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	115,252	328,248		6.00
7.00	Physical Therapy	0	0		7.00
8.00	Occupational Therapy	0	0		8.00
9.00	Speech Pathology	0	0		9.00
10.00	Medical Social Services	0	0		10.00
11.00	Home Health Aide	31,813	90,606		11.00
12.00	Supplies (see instructions)	262	746		12.00
13.00	Drugs	0	0		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
24.00	Total (sum of lines 1-23)		419,600		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 151319 HHA CCN: 157445 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-1 Part II Date/Time Prepared: 2/19/2015 8:48 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	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	-147,327	272,273	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	212,996	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 Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	58,793	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	484	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-147,327	272,273	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		147,327	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.541100	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-2 Part I
HHA CCN: 157445 | Date/Time Prepared: 2/19/2015 8:48 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	4,822	6,084	15,584	26,490	5,016	1.00
2.00	Skilled Nursing Care	328,248	0	0	0	328,248	62,152	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	90,606	0	0	0	90,606	17,156	7.00
8.00	Supplies (see instructions)	746	0	0	0	746	141	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)	419,600	4,822	6,084	15,584	446,090	84,465	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	13,763	0	4,808	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	13,763	0	4,808	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151319 | HHA CCN: 157445 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-2 Part I | Date/Time Prepared: 2/19/2015 8:48 am

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	Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		16.00	24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	0	50,077	0	50,077			1.00
2.00	Skilled Nursing Care	0	390,400	0	390,400	39,175	429,575	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	107,762	0	107,762	10,813	118,575	7.00
8.00	Supplies (see instructions)	0	887	0	887	89	976	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	549,126	0	549,126	50,077	549,126	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.					0.100345		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: 151319 HHA CCN: 157445 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-2 Part II Date/Time Prepared: 2/19/2015 8:48 am

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	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	505	505	285,272	0	26,490	505	1.00
2.00	Skilled Nursing Care	0	0	0	0	328,248	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	90,606	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	746	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)	505	505	285,272		446,090	505	20.00
21.00	Total cost to be allocated	4,822	6,084	15,584		84,465	13,763	21.00
22.00	Unit cost multiplier	9.548515	12.047525	0.054629		0.189345	27.253465	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (NRSE FTE'S)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		8.00	9.00	10.00	11.00	13.00	16.00	
1.00	Administrative and General	0	505	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	505	0	0	0	0	20.00
21.00	Total cost to be allocated	0	4,808	0	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	9.520792	0.000000	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

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	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	429,575		429,575	1,989	215.98	1.00
2.00	Physical Therapy	3.00	0	0	0	1,429	0.00	2.00
3.00	Occupational Therapy	4.00	0	0	0	399	0.00	3.00
4.00	Speech Pathology	5.00	0	0	0	33	0.00	4.00
5.00	Medical Social Services	6.00	0		0	4	0.00	5.00
6.00	Home Health Aide	7.00	118,575		118,575	682	173.86	6.00
7.00	Total (sum of lines 1-6)		548,150	0	548,150	4,536		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		21780	59	878			8.00
9.00	Physical Therapy		21780	66	621			9.00
10.00	Occupational Therapy		21780	22	164			10.00
11.00	Speech Pathology		21780	0	1			11.00
12.00	Medical Social Services		21780	0	2			12.00
13.00	Home Health Aide		21780	34	307			13.00
14.00	Total (sum of lines 8-13)			181	1,973			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	976	0	976	4,765	0.204827	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B 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	59	878		12,743	189,630		1.00
2.00	Physical Therapy	66	621		0	0		2.00
3.00	Occupational Therapy	22	164		0	0		3.00
4.00	Speech Pathology	0	1		0	0		4.00
5.00	Medical Social Services	0	2		0	0		5.00
6.00	Home Health Aide	34	307		5,911	53,375		6.00
7.00	Total (sum of lines 1-6)	181	1,973		18,654	243,005		7.00

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

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	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies							15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 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	202,373	1.00
2.00	Physical Therapy	0	2.00
3.00	Occupational Therapy	0	3.00
4.00	Speech Pathology	0	4.00
5.00	Medical Social Services	0	5.00
6.00	Home Health Aide	59,286	6.00
7.00	Total (sum of lines 1-6)	261,659	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
9.00	Physical Therapy		9.00
10.00	Occupational Therapy		10.00
11.00	Speech Pathology		11.00
12.00	Medical Social Services		12.00
13.00	Home Health Aide		13.00
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

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	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	0.323263	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.263114	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.304085	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.263480	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.534959	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 151319 | HHA CCN: 157445 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-4 Part I-II | Date/Time Prepared: 2/19/2015 8:48 am

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B 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	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	21,896	240,468	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	1,831	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	2,451	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	2,121	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	568	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	21,896	247,439	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	21,896	247,439	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	21,896	247,439	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	21,896	247,439	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	21,896	247,439	31.00
31.01	Sequestration adjustment (see instructions)	438	4,949	31.01
32.00	Interim payments (see instructions)	21,458	242,491	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33	0	-1	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	35.00

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

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		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		21,458		242,491	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)		21,458		242,491	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)		21,458		242,490	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00