

**ADAMS MEMORIAL HOSPITAL
DECATUR, INDIANA**

**PROVIDER NOS. 15-1330, 15-M330, 15-Z330,
15-5316 AND 15-7172**

**HOSPITAL STATEMENTS OF REIMBURSABLE COST
(MEDICARE AND MEDICAID PROGRAMS)**

DECEMBER 31, 2013

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).
 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY
 Provider CCN: 151330
 Period: From 01/01/2013 To 12/31/2013
 Worksheet S Parts I-III
 Date/Time Prepared: 5/30/2014 10:44 am

PART I - COST REPORT STATUS

Provider use only
 1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only
 5. 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. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN
 10. NPR Date:
 11. Contractor's Vendor Code: 4
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 5/30/2014 Time: 10:44 am

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 ADAMS MEMORIAL HOSPITAL (151330) for the cost reporting period beginning 01/01/2013 and ending 12/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: date: 5/30/2014 Time: 10:44 am
 tqOe7KgdF5Kxq.RSEsmTN95L8sE2U0
 z:lnA0vNR:ijaim4mgFFILVBASw4Xj
 eAWQ0Zqkgc0DMPTp
 PI: date: 5/30/2014 Time: 10:44 am
 0ZKzi4huQnq7.XSYXlck6lh1fi5sH0
 DQh1z0JiHcgd5PbgAez75wAqdGxYoE
 yc310gjPkx0krp0Z

(Signed)

Officer or Administrator of Provider(s)

Title

Date

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	348,643	16,802	0	1.00
2.00	Subprovider - IPF	0	229	0	0	2.00
3.00	Subprovider - IRF	0	0	0	0	3.00
5.00	Swing bed - SNF	0	0	0	0	5.00
6.00	Swing bed - NF	0	0	0	0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0	0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0	0	9.00
200.00	Total	0	348,872	16,802	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151330	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/29/2014 6:49 pm
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1.00	2.00		3.00		4.00			1.00	2.00		
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1100 MERCER AVENUE			PO Box:	Zip Code: 46733		County: ADAMS			1.00	
2.00	City: DECATUR			State: IN							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	ADAMS MEMORIAL HOSPITAL	151330	99915	1	11/01/2005	N	O	P	3.00
4.00	Subprovider - IPF	ADAMS MEMORIAL HOSPITAL	15M330	99915	4	11/01/2005	N	P	P	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ADAMS MEMORIAL HOSPITAL	15Z330	99915		11/01/2005	N	O	P	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									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:	To:		
						1.00	2.00		

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

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

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

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

	Urban/Rural S	Date of Geogr	
	1.00	2.00	

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151330	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/29/2014 6:49 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					39.00
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.	N				58.00
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00 61.00
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 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
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: 151330

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

Worksheet S-2
Part I
Date/Time Prepared:
5/29/2014 6:49 pm

	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.			Y		70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			N	0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	76.00
						1.00
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00
86.00	Did this facility establish a new other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
						V XIX 1.00 2.00
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	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	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 1.00	XIX 2.00		
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&RS in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N			108.00
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 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
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1			118.00
			Premiums 1.00	Losses 2.00	Insurance 3.00	
118.01	List amounts of malpractice premiums and paid losses:		116,006	0		0
				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)		Y		15H060	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151330		Period: From 01/01/2013 To 12/31/2013		Worksheet S-2 Part I Date/Time Prepared: 5/29/2014 6:49 pm	
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: ADAMS HEALTH NETWORK	Contractor's Name: WPS		Contractor's Number: 08101		141.00	
142.00	Street: 1100 MERCER AVE	PO BOX:				142.00	
143.00	City: DECATUR	State: IN		Zip Code: 46733		143.00	
144.00 Are provider based physicians' costs included in worksheet A?				1.00		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.				2.00		N 145.00	
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.				1.00		N 146.00	
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				2.00		N 147.00	
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				3.00		N 148.00	
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				4.00		N 149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
155.00 Hospital		N		N		N 155.00	
156.00 Subprovider - IPF		N		N		N 156.00	
157.00 Subprovider - IRF		N		N		N 157.00	
158.00 SUBPROVIDER		N		N		N 158.00	
159.00 SNF		N		N		N 159.00	
160.00 HOME HEALTH AGENCY		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	
		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.						N 167.00	
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0.00 168.00	
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)						170.00	

		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)	Y		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.	N		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
		Y/N	Date	Y/N
		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	05/14/2014	N
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		Y
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
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
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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 151330	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/29/2014 6:49 pm
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	Description	Part A		Part B	
		Y/N	Date	Y/N	
	0	1.00	2.00	3.00	
21.00	was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

Capital Related Cost

22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N		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		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		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		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		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y		Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		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		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		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		Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y		Y	35.00

	Y/N	Date
	1.00	2.00

Home Office Costs

36.00	Were home office costs claimed on the cost report?	Y		Y	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.	Y		Y	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		N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	Y		Y	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		N	40.00

	1.00	2.00
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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.	SKANDER	NASSER		41.00
42.00	Enter the employer/company name of the cost report preparer.	BRADLEY ASSOCIATES			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-237-5500	SKANDERN@BRADLEYCPA.COM		43.00

		Part B		
		Date		
		4.00		
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)			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)	05/14/2014		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.		PARTNER	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

Provider CCN: 151330	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part V Date/Time Prepared: 5/29/2014 6:49 pm
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1.00

Cost Report Preparer Contact Information

1.00	First Name	SKANDER	1.00
2.00	Last Name	NASSER	2.00
3.00	Title	PARTNER	3.00
4.00	Employer	BRADLEY ASSOCIATES	4.00
5.00	Phone Number	(317)237-5500	5.00
6.00	E-mail Address	SKANDERN@BRADELYCPA.COM	6.00
7.00	Department		7.00
8.00	Mailing Address 1	201 S CAPITOL AVE	8.00
9.00	Mailing Address 2	SUITE 700	9.00
10.00	City	INDIANAPOLIS	10.00
11.00	State	IN	11.00
12.00	Zip	46225	12.00

Officer or Administrator of Provider Contact Information

13.00	First Name	DANE	13.00
14.00	Last Name	WHEELER	14.00
15.00	Title	CFO	15.00
16.00	Employer	ADAMS HEALTH NETWORK	16.00
17.00	Phone Number	(260)724-2145	17.00
18.00	E-mail Address	DWHEELER@ADAMSHOSPITAL.COM	18.00
19.00	Department		19.00
20.00	Mailing Address 1	1100 MERCER AVE	20.00
21.00	Mailing Address 2	PO BOX 151	21.00
22.00	City	DECATUR	22.00
23.00	State	IN	23.00
24.00	Zip	46733	24.00

		Title V 1.00	Title XIX 2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient 1.00	Outpatient 2.00	
CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V 1.00	Title XIX 2.00	
RCE DISALLOWANCE				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151330

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2014 6:49 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	Title V
	Line Number				Visits / Trips	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	110,664.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	110,664.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	19,368.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,125	130,032.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	10	3,650		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		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	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		35				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

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)	2,155	295	4,542			1.00
2.00 HMO and other (see instructions)	966	0				2.00
3.00 HMO IPF Subprovider	122	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF			44			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	2,155	295	4,586			7.00
8.00 INTENSIVE CARE UNIT	366	30	807			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		47	384			13.00
14.00 Total (see instructions)	2,521	372	5,777	0.00	315.22	14.00
15.00 CAH visits	36,334	9,141	97,926			15.00
16.00 SUBPROVIDER - IPF	524	346	1,753	0.00	13.94	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	0.00	24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	329.16	27.00
28.00 Observation Bed Days		0	766			28.00
29.00 Ambulance Trips	811					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	69			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

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	584	108	1,524	1.00
2.00 HMO and other (see instructions)				255			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	584		108	1,524	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF	0.00	0	85		77	382	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	0.00						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

		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)	0.434642	1.00		
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid	1,929,565	2.00		
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00		
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00		
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00		
6.00	Medicaid charges	6,556,731	6.00		
7.00	Medicaid cost (line 1 times line 6)	2,849,831	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)	920,266	8.00		
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP	100,000	9.00		
10.00	Stand-alone SCHIP charges	200,000	10.00		
11.00	Stand-alone SCHIP cost (line 1 times line 10)	86,928	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)	920,266	19.00		
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,991,030	0	1,991,030	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	865,385	0	865,385	21.00
22.00	Partial payment by patients approved for charity care	788,745	0	788,745	22.00
23.00	Cost of charity care (line 21 minus line 22)	76,640	0	76,640	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		4,954,777		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		165,606		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		4,789,171		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		2,081,575		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,158,215		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,078,481		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151330

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

Worksheet A

Date/Time Prepared:
5/29/2014 6:49 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		2,650,643	2,650,643	45,940	2,696,583	1.00
2.00	00200		0	0	0	0	2.00
2.01	00201		83,466	83,466	0	83,466	2.01
3.00	00300		0	0	0	0	3.00
4.00	00400	0	4,964,261	4,964,261	0	4,964,261	4.00
5.00	00500	781,423	6,273,331	7,054,754	-42,132	7,012,622	5.00
7.00	00700	346,445	782,715	1,129,160	0	1,129,160	7.00
7.01	00701	54,504	111,488	165,992	0	165,992	7.01
7.02	00702	0	556,691	556,691	4,878	561,569	7.02
7.03	00703	0	105,661	105,661	-4,878	100,783	7.03
8.00	00800	42,252	122,157	164,409	0	164,409	8.00
9.00	00900	375,171	94,748	469,919	0	469,919	9.00
10.00	01000	576,544	670,636	1,247,180	-1,044,717	202,463	10.00
11.00	01100	0	0	0	1,044,717	1,044,717	11.00
13.00	01300	853,613	78,707	932,320	0	932,320	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	622,087	123,923	746,010	0	746,010	15.00
16.00	01600	343,852	311,316	655,168	0	655,168	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,008,327	251,800	2,260,127	366,227	2,626,354	30.00
31.00	03100	558,137	20,162	578,299	0	578,299	31.00
40.00	04000	866,269	131,932	998,201	-224,581	773,620	40.00
43.00	04300	0	0	0	182,338	182,338	43.00
44.00	04400	0	1,121	1,121	0	1,121	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,603,528	554,300	2,157,828	0	2,157,828	50.00
52.00	05200	603,436	46,963	650,399	-548,565	101,834	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	890,544	700,323	1,590,867	0	1,590,867	54.00
60.00	06000	962,032	1,522,146	2,484,178	0	2,484,178	60.00
65.00	06500	539,439	91,475	630,914	0	630,914	65.00
66.00	06600	494,831	42,264	537,095	0	537,095	66.00
67.00	06700	112,917	12,183	125,100	0	125,100	67.00
68.00	06800	99,546	9,052	108,598	0	108,598	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	958,017	958,017	0	958,017	71.00
72.00	07200	0	343,761	343,761	0	343,761	72.00
73.00	07300	0	1,504,341	1,504,341	0	1,504,341	73.00
76.00	03020	0	0	0	233,609	233,609	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	747,775	116,266	864,041	0	864,041	90.00
90.01	09001	605,710	40,216	645,926	0	645,926	90.01
90.02	09002	8,381	5,793	14,174	0	14,174	90.02
90.03	09003	850,676	47,606	898,282	0	898,282	90.03
91.00	09100	1,913,759	286,877	2,200,636	0	2,200,636	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	1,036,116	142,810	1,178,926	0	1,178,926	95.00
97.00	09700	0	0	0	0	0	97.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	0	0	0	116.00
118.00		17,897,314	23,759,151	41,656,465	12,836	41,669,301	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	717,079	147,391	864,470	0	864,470	194.01
194.02	07952	0	206,485	206,485	-12,836	193,649	194.02
194.03	07953	353,020	65,318	418,338	0	418,338	194.03
200.00		18,967,413	24,178,345	43,145,758	0	43,145,758	200.00

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	-144,450	2,552,133	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
2.01	00201 OTHER CAP	0	83,466	2.01
3.00	00300 OTHER CAP REL COSTS	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-356,643	4,607,618	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	45,262	7,057,884	5.00
7.00	00700 OPERATION OF PLANT	0	1,129,160	7.00
7.01	00701 BIO-MEDICAL	0	165,992	7.01
7.02	00702 UTILITIES - HOSPITAL	0	561,569	7.02
7.03	00703 UTILITIES - OFFSITE BLDGS	0	100,783	7.03
8.00	00800 LAUNDRY & LINEN SERVICE	0	164,409	8.00
9.00	00900 HOUSEKEEPING	0	469,919	9.00
10.00	01000 DIETARY	0	202,463	10.00
11.00	01100 CAFETERIA	-391,669	653,048	11.00
13.00	01300 NURSING ADMINISTRATION	0	932,320	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500 PHARMACY	0	746,010	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-24,125	631,043	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-670,098	1,956,256	30.00
31.00	03100 INTENSIVE CARE UNIT	0	578,299	31.00
40.00	04000 SUBPROVIDER - IPF	-82,588	691,032	40.00
43.00	04300 NURSERY	0	182,338	43.00
44.00	04400 SKILLED NURSING FACILITY	-1,121	0	44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-460,574	1,697,254	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	101,834	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	-1,171	1,589,696	54.00
60.00	06000 LABORATORY	-58,558	2,425,620	60.00
65.00	06500 RESPIRATORY THERAPY	-91,161	539,753	65.00
66.00	06600 PHYSICAL THERAPY	0	537,095	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	125,100	67.00
68.00	06800 SPEECH PATHOLOGY	0	108,598	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	958,017	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	343,761	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	-22,521	1,481,820	73.00
76.00	03020 OP PSYCH	0	233,609	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	-528,601	335,440	90.00
90.01	09001 CLINIC - AMO	-275,000	370,926	90.01
90.02	09002 CLINIC - AMH NEURO	0	14,174	90.02
90.03	09003 CLINIC - NIGLIAZZO	-641,153	257,129	90.03
91.00	09100 EMERGENCY	-982,632	1,218,004	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0	1,178,926	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
101.00	10100 HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS				
116.00	11600 HOSPICE	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-4,686,803	36,982,498	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950 TITLE XX	0	0	194.00
194.01	07951 OTHER NRCC	0	864,470	194.01
194.02	07952 OTHER MOBS	0	193,649	194.02
194.03	07953 MONROE	0	418,338	194.03
200.00	TOTAL (SUM OF LINES 118-199)	-4,686,803	38,458,955	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 151330

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

Worksheet Non-CMS W
Date/Time Prepared:
5/29/2014 6:49 pm

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	00200		2.00
2.01	OTHER CAP	00201		2.01
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
7.01	BIO-MEDICAL	00701		7.01
7.02	UTILITIES - HOSPITAL	00702		7.02
7.03	UTILITIES - OFFSITE BLDGS	00703		7.03
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
40.00	SUBPROVIDER - IPF	04000		40.00
43.00	NURSERY	04300		43.00
44.00	SKILLED NURSING FACILITY	04400		44.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.00	OP PSYCH	03020		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	09000		90.00
90.01	CLINIC - AMO	09001		90.01
90.02	CLINIC - AMH NEURO	09002		90.02
90.03	CLINIC - NIGLIAZZO	09003		90.03
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	09500		95.00
97.00	DURABLE MEDICAL EQUIP-SOLD	09700		97.00
101.00	HOME HEALTH AGENCY	10100		101.00
SPECIAL PURPOSE COST CENTERS				
116.00	HOSPICE	11600		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
194.00	TITLE XX	07950		194.00
194.01	OTHER NRCC	07951		194.01
194.02	OTHER MOBS	07952		194.02
194.03	MONROE	07953		194.03
200.00	TOTAL (SUM OF LINES 118-199)			200.00

Provider CCN: 151330

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

Worksheet A-6

Date/Time Prepared:
5/29/2014 6:49 pm

		Increases			
Cost Center		Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - OB, NURSERY AND L&D					
1.00	ADULTS & PEDIATRICS	30.00	339,783	26,444	1.00
2.00	NURSERY	43.00	169,172	13,166	2.00
	TOTALS		508,955	39,610	
B - INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	45,940	1.00
	TOTALS		0	45,940	
C - CAFETERIA					
1.00	CAFETERIA	11.00	482,950	561,767	1.00
	TOTALS		482,950	561,767	
D - O/P PSYCH					
1.00	OP PSYCH	76.00	194,898	29,683	1.00
	TOTALS		194,898	29,683	
E - HOSPITAL USE OF SWISS CITY					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,808	1.00
2.00	OP PSYCH	76.00	0	9,028	2.00
3.00	UTILITIES - HOSPITAL	7.02	0	4,878	3.00
	TOTALS		0	17,714	
500.00	Grand Total: Increases		1,186,803	694,714	500.00

Provider CCN: 151330

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

Worksheet A-6

Date/Time Prepared:
5/29/2014 6:49 pm

		Decreases					
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - OB, NURSERY AND L&D							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	508,955	39,610	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		508,955	39,610			
B - INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	45,940	12		1.00
	TOTALS		0	45,940			
C - CAFETERIA							
1.00	DIETARY	10.00	482,950	561,767	0		1.00
	TOTALS		482,950	561,767			
D - O/P PSYCH							
1.00	SUBPROVIDER - IPF	40.00	194,898	29,683	0		1.00
	TOTALS		194,898	29,683			
E - HOSPITAL USE OF SWISS CITY							
1.00	OTHER MOBS	194.02	0	12,836	0		1.00
2.00	UTILITIES - OFFSITE BLDGS	7.03	0	4,878	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	17,714			
500.00	Grand Total: Decreases		1,186,803	694,714			500.00

Increases			Decreases			
Cost Center	Line #	Salary	Cost Center	Line #	Salary	
2.00	3.00	4.00	6.00	7.00	8.00	
A - OB, NURSERY AND L&D						
1.00	ADULTS & PEDIATRICS	30.00	339,783	DELIVERY ROOM & LABOR ROOM	52.00	508,955 1.00
2.00	NURSERY	43.00	169,172		0.00	0 2.00
	TOTALS		508,955	TOTALS		508,955
B - INSURANCE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	ADMINISTRATIVE & GENERAL	5.00	0 1.00
	TOTALS		0	TOTALS		0
C - CAFETERIA						
1.00	CAFETERIA	11.00	482,950	DIETARY	10.00	482,950 1.00
	TOTALS		482,950	TOTALS		482,950
D - O/P PSYCH						
1.00	OP PSYCH	76.00	194,898	SUBPROVIDER - IPF	40.00	194,898 1.00
	TOTALS		194,898	TOTALS		194,898
E - HOSPITAL USE OF SWISS CITY						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	OTHER MOBS	194.02	0 1.00
2.00	OP PSYCH	76.00	0	UTILITIES - OFFSITE BLDGS	7.03	0 2.00
3.00	UTILITIES - HOSPITAL	7.02	0		0.00	0 3.00
	TOTALS		0	TOTALS		0
500.00	Grand Total: Increases		1,186,803	Grand Total: Decreases		1,186,803 500.00

	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	360,342	0	0	0	242 1.00
2.00	Land Improvements	1,463,095	67,757	0	67,757	0 2.00
3.00	Buildings and Fixtures	38,732,953	0	0	0	1,079,870 3.00
4.00	Building Improvements	0	0	0	0	0 4.00
5.00	Fixed Equipment	4,315,156	0	0	0	5,362 5.00
6.00	Movable Equipment	18,497,347	2,427,948	0	2,427,948	0 6.00
7.00	HIT designated Assets	0	0	0	0	0 7.00
8.00	Subtotal (sum of lines 1-7)	63,368,893	2,495,705	0	2,495,705	1,085,474 8.00
9.00	Reconciling Items	0	0	0	0	0 9.00
10.00	Total (line 8 minus line 9)	63,368,893	2,495,705	0	2,495,705	1,085,474 10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	360,100	0			1.00
2.00	Land Improvements	1,530,852	0			2.00
3.00	Buildings and Fixtures	37,653,083	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	4,309,794	0			5.00
6.00	Movable Equipment	20,925,295	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	64,779,124	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	64,779,124	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151330

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

Worksheet A-7
Part II
Date/Time Prepared:
5/29/2014 6:49 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,650,643	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
2.01	OTHER CAP	83,466	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	2,734,109	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,650,643				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
2.01	OTHER CAP	0	83,466				2.01
3.00	Total (sum of lines 1-2)	0	2,734,109				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151330

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

Worksheet A-7
Part III
Date/Time Prepared:
5/29/2014 6:49 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
2.01	OTHER CAP	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,506,193	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
2.01	OTHER CAP	0	0	0	83,466	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	2,589,659	0	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	45,940	0	0	2,552,133	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
2.01	OTHER CAP	0	0	0	0	83,466	2.01
3.00	Total (sum of lines 1-2)	0	45,940	0	0	2,635,599	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7	Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-144,450	NEW CAP REL COSTS-BLDG & FIXT	1.00		9	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
2.01 Investment income - OTHER CAP (chapter 2)		0	OTHER CAP	2.01		0	2.01
3.00 Investment income - other (chapter 2)		0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00		0	7.00
8.00 Television and radio service (chapter 21)	A	-3,974	ADMINISTRATIVE & GENERAL	5.00		0	8.00
9.00 Parking lot (chapter 21)		0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-3,408,306				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	-410,407				0	12.00
13.00 Laundry and linen service		0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-391,669	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	B	-22,521	DRUGS CHARGED TO PATIENTS	73.00		0	17.00
18.00 Sale of medical records and abstracts	B	-24,125	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
27.01 Depreciation - OTHER CAP		0	OTHER CAP	2.01		0	27.01
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant		0		0.00		0	29.00
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

Provider CCN: 151330

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

worksheet A-8

Date/Time Prepared:
5/29/2014 6:49 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted			Ref.
			Cost Center	Line #	Wkst. A-7	
			1.00	2.00	3.00	
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		0		0.00		0 32.00
33.00 IHA DUES	A	-898	ADMINISTRATIVE & GENERAL	5.00		0 33.00
34.00 AHA DUES	A	-3,433	ADMINISTRATIVE & GENERAL	5.00		0 34.00
35.00 CRNA PRO FEES	A	-90,000	OPERATING ROOM	50.00		0 35.00
36.00 RAD EQUIP INT EXP - UNECESSARY BORRO	A	-1,171	RADIOLOGY-DIAGNOSTIC	54.00	11	36.00
37.00 TRANSPORTATION	B	-3,988	ADMINISTRATIVE & GENERAL	5.00		0 37.00
38.00 OB RENTALS	B	-345	ADMINISTRATIVE & GENERAL	5.00		0 38.00
39.00 WORTHMAN FITNESS CENTER	B	-91,161	RESPIRATORY THERAPY	65.00		0 39.00
40.00 MISC INCOME	B	-13,163	ADMINISTRATIVE & GENERAL	5.00		0 40.00
41.00 NONALLOWABLE PHYSICIAN BENEFITS	A	-306,418	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 41.00
42.00		0		0.00		0 42.00
43.00		0		0.00		0 43.00
44.00 ECU RUN-OFF EXPENSES	A	-1,121	SKILLED NURSING FACILITY	44.00		0 44.00
45.02 HOSPITAL PROVIDER TAX	A	481,470	ADMINISTRATIVE & GENERAL	5.00		0 45.02
45.06 CRNA FEES	A	-200,898	OPERATING ROOM	50.00		0 45.06
45.07 CRNA BENEFITS	A	-50,225	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 45.07
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,686,803				50.00

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

Provider CCN: 151330

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

Worksheet A-8-1

Date/Time Prepared:
5/29/2014 6:49 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED					
HOME OFFICE COSTS:					
1.00	0.00		0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	1,569,232	1,979,639	2.00
3.00	0.00		0	0	3.00
4.00	0.00		0	0	4.00
5.00	0		1,569,232	1,979,639	5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Symbol (1)	Name	Percentage of Ownership	Related organization(s) and/or Home office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	B		0.00	ADAMS HEALTH NETWORK	0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 151330

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

worksheet A-8-1

Date/Time Prepared:
5/29/2014 6:49 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED			
HOME OFFICE COSTS:			
1.00	0	0	1.00
2.00	-410,407	0	2.00
3.00	0	0	3.00
4.00	0	0	4.00
5.00	-410,407		5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Related Organization(s) and/or Home Office	Type of Business
	6.00

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	MANAGEMENT	6.00
7.00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151330

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

Worksheet A-8-2

Date/Time Prepared:
5/29/2014 6:49 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	40.00	SUBPROVIDER - IPF	82,588	82,588	0	0	0	1.00
2.00	60.00	LABORATORY	60,000	58,558	1,442	0	0	2.00
3.00	91.00	EMERGENCY	1,224,576	956,149	268,427	0	0	3.00
4.00	91.00	EMERGENCY	275,000	26,483	248,517	0	0	4.00
5.00	90.00	CLINIC	528,601	528,601	0	0	0	5.00
6.00	90.01	CLINIC - AMO	275,000	275,000	0	0	0	6.00
7.00	90.03	CLINIC - NIGLIAZZO	641,153	641,153	0	0	0	7.00
8.00	50.00	OPERATING ROOM	319,676	169,676	150,000	0	0	8.00
9.00	30.00	ADULTS & PEDIATRICS	670,098	670,098	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,076,692	3,408,306	668,386			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	40.00	SUBPROVIDER - IPF	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	90.01	CLINIC - AMO	0	0	0	0	0	6.00
7.00	90.03	CLINIC - NIGLIAZZO	0	0	0	0	0	7.00
8.00	50.00	OPERATING ROOM	0	0	0	0	0	8.00
9.00	30.00	ADULTS & PEDIATRICS	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	40.00	SUBPROVIDER - IPF	0	0	0	82,588		1.00
2.00	60.00	LABORATORY	0	0	0	58,558		2.00
3.00	91.00	EMERGENCY	0	0	0	956,149		3.00
4.00	91.00	EMERGENCY	0	0	0	26,483		4.00
5.00	90.00	CLINIC	0	0	0	528,601		5.00
6.00	90.01	CLINIC - AMO	0	0	0	275,000		6.00
7.00	90.03	CLINIC - NIGLIAZZO	0	0	0	641,153		7.00
8.00	50.00	OPERATING ROOM	0	0	0	169,676		8.00
9.00	30.00	ADULTS & PEDIATRICS	0	0	0	670,098		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,408,306		200.00

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP	OTHER CAP		
		1.00	2.00	2.01		
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	2,552,133	2,552,133				1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	0		0			2.00
2.01 00201 OTHER CAP	83,466		0	83,466		2.01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	4,607,618		0	0	4,607,618	4.00
5.00 00500 ADMINISTRATIVE & GENERAL	7,057,884	316,062	0	13,103	232,300	5.00
7.00 00700 OPERATION OF PLANT	1,129,160	391,810	0	10,511	102,990	7.00
7.01 00701 BIO-MEDICAL	165,992	9,327	0	247	16,203	7.01
7.02 00702 UTILITIES - HOSPITAL	561,569	0	0	0	0	7.02
7.03 00703 UTILITIES - OFFSITE BLDGS	100,783	0	0	0	0	7.03
8.00 00800 LAUNDRY & LINEN SERVICE	164,409	36,986	0	978	12,561	8.00
9.00 00900 HOUSEKEEPING	469,919	50,356	0	1,557	111,530	9.00
10.00 01000 DIETARY	202,463	14,974	0	396	27,823	10.00
11.00 01100 CAFETERIA	653,048	133,783	0	3,537	143,570	11.00
13.00 01300 NURSING ADMINISTRATION	932,320	12,557	0	332	253,760	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00 01500 PHARMACY	746,010	33,906	0	896	184,933	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	631,043	54,313	0	1,436	102,220	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	1,956,256	416,131	0	11,001	498,837	30.00
31.00 03100 INTENSIVE CARE UNIT	578,299	68,967	0	1,823	165,922	31.00
40.00 04000 SUBPROVIDER - IPF	691,032	152,929	0	4,043	199,584	40.00
43.00 04300 NURSERY	182,338	5,348	0	141	50,291	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1,697,254	234,560	0	6,201	366,530	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	101,834	0	0	0	28,087	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,589,696	189,423	0	5,008	264,739	54.00
60.00 06000 LABORATORY	2,425,620	68,710	0	2,220	285,991	60.00
65.00 06500 RESPIRATORY THERAPY	539,753	87,471	0	2,312	160,363	65.00
66.00 06600 PHYSICAL THERAPY	537,095	74,336	0	1,965	147,102	66.00
67.00 06700 OCCUPATIONAL THERAPY	125,100	2,139	0	57	33,568	67.00
68.00 06800 SPEECH PATHOLOGY	108,598	1,070	0	28	29,593	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	958,017	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	343,761	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,481,820	0	0	0	0	73.00
76.00 03020 OP PSYCH	233,609	0	0	0	57,939	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	335,440	0	0	2,480	65,156	90.00
90.01 09001 CLINIC - AMO	370,926	0	0	1,106	98,313	90.01
90.02 09002 CLINIC - AMH NEURO	14,174	0	0	0	2,491	90.02
90.03 09003 CLINIC - NIGLIAZZO	257,129	0	0	1,315	62,287	90.03
91.00 09100 EMERGENCY	1,218,004	115,665	0	3,058	276,804	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	1,178,926	0	0	2,445	308,014	95.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 11600 HOSPICE	0	0	0	0	0	116.00
118.00	36,982,498	2,470,823	0	78,196	4,289,501	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,990	0	370	0	190.00
194.00 07950 TITLE XX	0	0	0	0	0	194.00
194.01 07951 OTHER NRCC	864,470	67,320	0	3,931	213,172	194.01
194.02 07952 OTHER MOBS	193,649	0	0	0	0	194.02
194.03 07953 MONROE	418,338	0	0	969	104,945	194.03
200.00						200.00
201.00						201.00
202.00						202.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 TOTAL (sum lines 118-201)	38,458,955	2,552,133	0	83,466	4,607,618	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151330

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2014 6:49 pm

Cost Center Description		Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	BIO-MEDICAL	UTILITIES - HOSPITAL	
		4A	5.00	7.00	7.01	7.02	
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
2.01	00201	OTHER CAP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,619,349	7,619,349			5.00
7.00	00700	OPERATION OF PLANT	1,634,471	403,819	2,038,290		7.00
7.01	00701	BIO-MEDICAL	191,769	47,379	8,397	247,545	7.01
7.02	00702	UTILITIES - HOSPITAL	561,569	138,743	0	0	700,312
7.03	00703	UTILITIES - OFFSITE BLDGS	100,783	24,900	0	0	0
8.00	00800	LAUNDRY & LINEN SERVICE	214,934	53,102	33,299	0	14,116
9.00	00900	HOUSEKEEPING	633,362	156,481	53,021	0	19,219
10.00	01000	DIETARY	245,656	60,693	13,482	0	5,715
11.00	01100	CAFETERIA	933,938	230,742	120,448	0	51,059
13.00	01300	NURSING ADMINISTRATION	1,198,969	296,222	11,305	0	4,792
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	965,745	238,601	30,526	0	12,940
16.00	01600	MEDICAL RECORDS & LIBRARY	789,012	194,936	48,899	0	20,729
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,882,225	712,088	374,653	41,900	158,819
31.00	03100	INTENSIVE CARE UNIT	815,011	201,360	62,092	1,016	26,322
40.00	04000	SUBPROVIDER - IPF	1,047,588	258,821	137,685	81	58,366
43.00	04300	NURSERY	238,118	58,830	4,815	331	2,041
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,304,545	569,370	211,178	64,749	89,521
52.00	05200	DELIVERY ROOM & LABOR ROOM	129,921	32,099	0	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,048,866	506,201	170,541	104,655	72,294
60.00	06000	LABORATORY	2,782,541	687,466	75,612	10,850	26,224
65.00	06500	RESPIRATORY THERAPY	789,899	195,156	78,751	12,457	33,384
66.00	06600	PHYSICAL THERAPY	760,498	187,892	66,926	4,912	28,371
67.00	06700	OCCUPATIONAL THERAPY	160,864	39,744	1,926	0	816
68.00	06800	SPEECH PATHOLOGY	139,289	34,413	963	0	408
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	958,017	236,692	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	343,761	84,931	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,481,820	366,104	0	0	0
76.00	03020	OP PSYCH	291,548	72,031	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	403,076	99,586	84,471	104	0
90.01	09001	CLINIC - AMO	470,345	116,205	37,652	0	0
90.02	09002	CLINIC - AMH NEURO	16,665	4,117	0	454	0
90.03	09003	CLINIC - NIGLIAZZO	320,731	79,241	44,778	0	0
91.00	09100	EMERGENCY	1,613,531	398,645	104,135	1,314	44,144
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,489,385	367,973	83,258	4,178	0
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	36,577,801	7,154,583	1,858,813	247,001	669,280
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,360	3,548	12,596	0	5,339
194.00	07950	TITLE XX	0	0	0	0	0
194.01	07951	OTHER NRCC	1,148,893	283,850	133,871	544	25,693
194.02	07952	OTHER MOBS	193,649	47,844	0	0	0
194.03	07953	MONROE	524,252	129,524	33,010	0	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	38,458,955	7,619,349	2,038,290	247,545	700,312

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151330

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

Worksheet B
Part I
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Cost Center Description		UTILITIES - OFFSITE BLDGS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.03	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
7.01	00701						7.01
7.02	00702						7.02
7.03	00703	125,683					7.03
8.00	00800	0	315,451				8.00
9.00	00900	0	55,223	917,306			9.00
10.00	01000	0	2,597	6,363	334,506		10.00
11.00	01100	0	13,400	56,848	0	1,406,435	11.00
13.00	01300	0	0	5,336	0	66,115	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	14,407	0	39,683	15.00
16.00	01600	0	0	23,079	0	41,943	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	53,169	176,822	215,817	211,410	30.00
31.00	03100	0	14,088	29,306	37,415	54,216	31.00
40.00	04000	0	10,011	64,983	81,274	80,914	40.00
43.00	04300	0	0	2,272	0	15,259	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	49,199	99,670	0	94,387	50.00
52.00	05200	0	8,086	0	0	8,523	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	24,036	80,490	0	92,671	54.00
60.00	06000	0	249	35,687	0	123,220	60.00
65.00	06500	0	9,668	37,168	0	63,902	65.00
66.00	06600	0	16,812	31,587	0	79,083	66.00
67.00	06700	0	0	909	0	40,023	67.00
68.00	06800	0	0	454	0	11,070	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03020	0	2,906	0	0	23,489	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	1,805	39,868	0	47,814	90.00
90.01	09001	7,596	69	17,771	0	29,918	90.01
90.02	09002	0	10	0	0	1,041	90.02
90.03	09003	0	437	21,134	0	22,933	90.03
91.00	09100	0	36,869	49,149	0	66,383	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	9,956	14,792	39,295	0	138,763	95.00
97.00	09700	0	0	0	0	0	97.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	0	0	0	116.00
118.00		17,552	313,426	832,598	334,506	1,352,760	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	5,945	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	15,372	1,416	63,183	0	53,675	194.01
194.02	07952	92,759	0	0	0	0	194.02
194.03	07953	0	609	15,580	0	0	194.03
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		125,683	315,451	917,306	334,506	1,406,435	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151330

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

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Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal		
		13.00	14.00	15.00	16.00	24.00		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
2.00	00200						2.00	
2.01	00201						2.01	
4.00	00400						4.00	
5.00	00500						5.00	
7.00	00700						7.00	
7.01	00701						7.01	
7.02	00702						7.02	
7.03	00703						7.03	
8.00	00800						8.00	
9.00	00900						9.00	
10.00	01000						10.00	
11.00	01100						11.00	
13.00	01300	1,582,739					13.00	
14.00	01400	0	0				14.00	
15.00	01500	0		1,301,902			15.00	
16.00	01600	0	0	0	1,118,598		16.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	630,033	0	0	344,842	5,801,778	30.00	
31.00	03100	161,573	0	0	29,282	1,431,681	31.00	
40.00	04000	241,137	0	0	71,215	2,052,075	40.00	
43.00	04300	45,475	0	0	2,360	369,501	43.00	
44.00	04400	0	0	0	0	0	44.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	281,289	0	0	91,179	3,855,087	50.00	
52.00	05200	25,399	0	0	0	204,028	52.00	
53.00	05300	0	0	0	0	0	53.00	
54.00	05400	0	0	0	12,785	3,112,539	54.00	
60.00	06000	0	0	0	0	3,741,849	60.00	
65.00	06500	0	0	0	7,219	1,227,604	65.00	
66.00	06600	0	0	0	0	1,176,081	66.00	
67.00	06700	0	0	0	0	244,282	67.00	
68.00	06800	0	0	0	0	186,597	68.00	
69.00	06900	0	0	0	0	0	69.00	
71.00	07100	0	0	0	0	1,194,709	71.00	
72.00	07200	0	0	0	0	428,692	72.00	
73.00	07300	0	0	1,301,902	0	3,149,826	73.00	
76.00	03020	0	0	0	20,676	410,650	76.00	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	0	0	0	6,454	683,178	90.00	
90.01	09001	0	0	0	10,672	690,228	90.01	
90.02	09002	0	0	0	2,487	24,774	90.02	
90.03	09003	0	0	0	8,437	497,691	90.03	
91.00	09100	197,833	0	0	504,126	3,016,129	91.00	
92.00	09200	0	0	0	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	0	0	0	0	2,147,600	95.00	
97.00	09700	0	0	0	0	0	97.00	
101.00	10100	0	0	0	0	0	101.00	
SPECIAL PURPOSE COST CENTERS								
116.00	11600	0	0	0	0	0	116.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)		1,582,739	0	1,301,902	1,111,734	35,646,579	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	0	0	0	0	41,788	190.00	
194.00	07950	0	0	0	0	0	194.00	
194.01	07951	0	0	0	3,432	1,729,929	194.01	
194.02	07952	0	0	0	0	334,252	194.02	
194.03	07953	0	0	0	3,432	706,407	194.03	
200.00	Cross Foot Adjustments		0	0	0	0	200.00	
201.00	Negative Cost Centers		0	0	0	0	201.00	
202.00	TOTAL (sum lines 118-201)		1,582,739	0	1,301,902	1,118,598	38,458,955	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151330

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

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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
2.01	00201	OTHER CAP		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
7.01	00701	BIO-MEDICAL		7.01
7.02	00702	UTILITIES - HOSPITAL		7.02
7.03	00703	UTILITIES - OFFSITE BLDGS		7.03
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03020	OP PSYCH	0	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
90.01	09001	CLINIC - AMO	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	90.03
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
194.00	07950	TITLE XX	0	194.00
194.01	07951	OTHER NRCC	0	194.01
194.02	07952	OTHER MOBS	0	194.02
194.03	07953	MONROE	0	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)	0	202.00

Provider CCN: 151330

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

Worksheet Non-CMS W

Date/Time Prepared:
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Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
2.01	OTHER CAP	30	SQUARE FEET	2.01
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	30	SQUARE FEET	7.00
7.01	BIO-MEDICAL	32	COST	7.01
7.02	UTILITIES - HOSPITAL	1	SQUARE FEET	7.02
7.03	UTILITIES - OFFSITE BLDGS	33	COST	7.03
8.00	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	30	SQUARE FEET	9.00
10.00	DIETARY	10	MEALS SERVED	10.00
11.00	CAFETERIA	11	MEALS SERVED	11.00
13.00	NURSING ADMINISTRATION	13	DIRECT NURS. HRS.	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	14.00
15.00	PHARMACY	15	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	16	TIME SPENT	16.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151330

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal
		NEW BLDG & FIXT	NEW MVBLE EQUIP	OTHER CAP	
		0	1.00	2.00	
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
2.01 00201	OTHER CAP				2.01
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	61,476	316,062	13,103	390,641
7.00 00700	OPERATION OF PLANT		391,810	10,511	402,321
7.01 00701	BIO-MEDICAL	0	9,327	247	9,574
7.02 00702	UTILITIES - HOSPITAL	0	0	0	0
7.03 00703	UTILITIES - OFFSITE BLDGS	0	0	0	0
8.00 00800	LAUNDRY & LINEN SERVICE	0	36,986	978	37,964
9.00 00900	HOUSEKEEPING	0	50,356	1,557	51,913
10.00 01000	DIETARY	0	14,974	396	15,370
11.00 01100	CAFETERIA	0	133,783	3,537	137,320
13.00 01300	NURSING ADMINISTRATION	0	12,557	332	12,889
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0
15.00 01500	PHARMACY	0	33,906	896	34,802
16.00 01600	MEDICAL RECORDS & LIBRARY	0	54,313	1,436	55,749
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	0	416,131	11,001	427,132
31.00 03100	INTENSIVE CARE UNIT	0	68,967	1,823	70,790
40.00 04000	SUBPROVIDER - IPF	0	152,929	4,043	156,972
43.00 04300	NURSERY	0	5,348	141	5,489
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	234,560	6,201	240,761
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0
53.00 05300	ANESTHESIOLOGY	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	189,423	5,008	194,431
60.00 06000	LABORATORY	0	68,710	2,220	70,930
65.00 06500	RESPIRATORY THERAPY	0	87,471	2,312	89,783
66.00 06600	PHYSICAL THERAPY	0	74,336	1,965	76,301
67.00 06700	OCCUPATIONAL THERAPY	0	2,139	57	2,196
68.00 06800	SPEECH PATHOLOGY	0	1,070	28	1,098
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0
76.00 03020	OP PSYCH	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00 09000	CLINIC	0	0	2,480	2,480
90.01 09001	CLINIC - AMO	0	0	1,106	1,106
90.02 09002	CLINIC - AMH NEURO	0	0	0	0
90.03 09003	CLINIC - NIGLIAZZO	0	0	1,315	1,315
91.00 09100	EMERGENCY	0	115,665	3,058	118,723
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0
OTHER REIMBURSABLE COST CENTERS					
95.00 09500	AMBULANCE SERVICES	0	0	2,445	2,445
97.00 09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0
101.00 10100	HOME HEALTH AGENCY	0	0	0	0
SPECIAL PURPOSE COST CENTERS					
116.00 11600	HOSPICE	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	61,476	2,470,823	78,196	2,610,495
NONREIMBURSABLE COST CENTERS					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,990	370	14,360
194.00 07950	TITLE XX	0	0	0	0
194.01 07951	OTHER NRCC	0	67,320	3,931	71,251
194.02 07952	OTHER MOBS	0	0	0	0
194.03 07953	MONROE	0	0	969	969
200.00	Cross Foot Adjustments				0
201.00	Negative Cost Centers				0
202.00	TOTAL (sum lines 118-201)	61,476	2,552,133	83,466	2,697,075

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151330

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2014 6:49 pm

Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT 4.00	ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	BIO-MEDICAL 7.01	UTILITIES - HOSPITAL 7.02	
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
2.01	00201	OTHER CAP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	390,641			5.00
7.00	00700	OPERATION OF PLANT	0	20,704	423,025		7.00
7.01	00701	BIO-MEDICAL	0	2,429	1,743	13,746	7.01
7.02	00702	UTILITIES - HOSPITAL	0	7,113	0	0	7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	0	1,277	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,723	6,911	0	8.00
9.00	00900	HOUSEKEEPING	0	8,023	11,004	0	9.00
10.00	01000	DIETARY	0	3,112	2,798	0	10.00
11.00	01100	CAFETERIA	0	11,830	24,998	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	15,187	2,346	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	12,233	6,335	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,994	10,149	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	36,504	77,754	2,328	30.00
31.00	03100	INTENSIVE CARE UNIT	0	10,324	12,887	56	31.00
40.00	04000	SUBPROVIDER - IPF	0	13,270	28,575	4	40.00
43.00	04300	NURSERY	0	3,016	999	18	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	29,192	43,828	3,597	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,646	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	25,953	35,394	5,809	54.00
60.00	06000	LABORATORY	0	35,246	15,692	603	60.00
65.00	06500	RESPIRATORY THERAPY	0	10,006	16,344	692	65.00
66.00	06600	PHYSICAL THERAPY	0	9,633	13,890	273	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,038	400	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,764	200	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,135	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,354	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18,770	0	0	73.00
76.00	03020	OP PSYCH	0	3,693	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	5,106	17,531	6	90.00
90.01	09001	CLINIC - AMO	0	5,958	7,814	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	211	0	25	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	4,063	9,293	0	90.03
91.00	09100	EMERGENCY	0	20,439	21,612	73	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	448	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	18,866	17,279	232	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	366,812	385,776	13,716	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	182	2,614	0	190.00
194.00	07950	TITLE XX	0	0	0	0	194.00
194.01	07951	OTHER NRCC	0	14,553	27,784	30	194.01
194.02	07952	OTHER MOBS	0	2,453	0	0	194.02
194.03	07953	MONROE	0	6,641	6,851	0	194.03
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	390,641	423,025	13,746	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151330

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

Worksheet B
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Cost Center Description		UTILITIES - OFFSITE BLDGS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.03	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
7.01	00701						7.01
7.02	00702						7.02
7.03	00703	1,277					7.03
8.00	00800	0	47,741				8.00
9.00	00900	0	8,358	79,493			9.00
10.00	01000	0	393	551	22,282		10.00
11.00	01100	0	2,028	4,926	0	181,621	11.00
13.00	01300	0	0	462	0	8,538	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	1,249	0	5,124	15.00
16.00	01600	0	0	2,000	0	5,416	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	8,047	15,326	14,376	27,302	30.00
31.00	03100	0	2,132	2,540	2,492	7,001	31.00
40.00	04000	0	1,515	5,631	5,414	10,449	40.00
43.00	04300	0	0	197	0	1,970	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	7,446	8,637	0	12,189	50.00
52.00	05200	0	1,224	0	0	1,101	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	3,638	6,975	0	11,967	54.00
60.00	06000	0	38	3,093	0	15,912	60.00
65.00	06500	0	1,463	3,221	0	8,252	65.00
66.00	06600	0	2,544	2,737	0	10,212	66.00
67.00	06700	0	0	79	0	5,168	67.00
68.00	06800	0	0	39	0	1,430	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03020	0	440	0	0	3,033	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	273	3,455	0	6,175	90.00
90.01	09001	77	10	1,540	0	3,864	90.01
90.02	09002	0	1	0	0	134	90.02
90.03	09003	0	66	1,831	0	2,962	90.03
91.00	09100	0	5,580	4,259	0	8,572	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	101	2,239	3,405	0	17,919	95.00
97.00	09700	0	0	0	0	0	97.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	0	0	0	116.00
118.00		178	47,435	72,153	22,282	174,690	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	515	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	156	214	5,475	0	6,931	194.01
194.02	07952	943	0	0	0	0	194.02
194.03	07953	0	92	1,350	0	0	194.03
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		1,277	47,741	79,493	22,282	181,621	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151330

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

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Part II
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Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OTHER CAP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	BIO-MEDICAL						7.01
7.02	00702	UTILITIES - HOSPITAL						7.02
7.03	00703	UTILITIES - OFFSITE BLDGS						7.03
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	39,471					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0				14.00
15.00	01500	PHARMACY	0	0	59,874			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	83,519		16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,712	0	0	25,747	651,843	30.00
31.00	03100	INTENSIVE CARE UNIT	4,029	0	0	2,186	114,704	31.00
40.00	04000	SUBPROVIDER - IPF	6,014	0	0	5,317	233,754	40.00
43.00	04300	NURSERY	1,134	0	0	176	13,020	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,015	0	0	6,808	360,382	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	633	0	0	0	4,604	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	955	285,856	54.00
60.00	06000	LABORATORY	0	0	0	0	141,780	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	539	130,639	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	115,878	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	9,889	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	4,535	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	12,135	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	4,354	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	59,874	0	78,644	73.00
76.00	03020	OP PSYCH	0	0	0	1,544	8,710	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	482	35,508	90.00
90.01	09001	CLINIC - AMO	0	0	0	797	21,166	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	186	557	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0	630	20,160	90.03
91.00	09100	EMERGENCY	4,934	0	0	37,640	222,280	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	62,486	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	39,471	0	59,874	83,007	2,532,884	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	17,725	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	0	0	0	256	126,911	194.01
194.02	07952	OTHER MOBS	0	0	0	0	3,396	194.02
194.03	07953	MONROE	0	0	0	256	16,159	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)	39,471	0	59,874	83,519	2,697,075	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151330

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

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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
2.01	00201	OTHER CAP		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
7.01	00701	BIO-MEDICAL		7.01
7.02	00702	UTILITIES - HOSPITAL		7.02
7.03	00703	UTILITIES - OFFSITE BLDGS		7.03
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	651,843
31.00	03100	INTENSIVE CARE UNIT	0	114,704
40.00	04000	SUBPROVIDER - IPF	0	233,754
43.00	04300	NURSERY	0	13,020
44.00	04400	SKILLED NURSING FACILITY	0	0
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	360,382
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,604
53.00	05300	ANESTHESIOLOGY	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	285,856
60.00	06000	LABORATORY	0	141,780
65.00	06500	RESPIRATORY THERAPY	0	130,639
66.00	06600	PHYSICAL THERAPY	0	115,878
67.00	06700	OCCUPATIONAL THERAPY	0	9,889
68.00	06800	SPEECH PATHOLOGY	0	4,535
69.00	06900	ELECTROCARDIOLOGY	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,135
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,354
73.00	07300	DRUGS CHARGED TO PATIENTS	0	78,644
76.00	03020	OP PSYCH	0	8,710
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	35,508
90.01	09001	CLINIC - AMO	0	21,166
90.02	09002	CLINIC - AMH NEURO	0	557
90.03	09003	CLINIC - NIGLIAZZO	0	20,160
91.00	09100	EMERGENCY	0	222,280
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	62,486
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0
101.00	10100	HOME HEALTH AGENCY	0	0
SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,532,884
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,725
194.00	07950	TITLE XX	0	0
194.01	07951	OTHER NRCC	0	126,911
194.02	07952	OTHER MOBS	0	3,396
194.03	07953	MONROE	0	16,159
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	2,697,075

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
		NEW BLDG & FIXT (SQARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	OTHER CAP (SQARE FEET)			
		1.00	2.00	2.01			
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	119,305				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0			2.00
2.01	00201	OTHER CAP		0	147,594		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0		15,499,355	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,775	0	23,174	781,423	-7,619,349
7.00	00700	OPERATION OF PLANT	18,316	0	18,586	346,445	0
7.01	00701	BIO-MEDICAL	436	0	436	54,504	0
7.02	00702	UTILITIES - HOSPITAL	0	0	0	0	0
7.03	00703	UTILITIES - OFFSITE BLDGS	0	0	0	0	0
8.00	00800	LAUNDRY & LINEN SERVICE	1,729	0	1,729	42,252	0
9.00	00900	HOUSEKEEPING	2,354	0	2,753	375,171	0
10.00	01000	DIETARY	700	0	700	93,594	0
11.00	01100	CAFETERIA	6,254	0	6,254	482,950	0
13.00	01300	NURSING ADMINISTRATION	587	0	587	853,613	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	1,585	0	1,585	622,087	0
16.00	01600	MEDICAL RECORDS & LIBRARY	2,539	0	2,539	343,852	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	19,453	0	19,453	1,678,012	0
31.00	03100	INTENSIVE CARE UNIT	3,224	0	3,224	558,137	0
40.00	04000	SUBPROVIDER - IPF	7,149	0	7,149	671,371	0
43.00	04300	NURSERY	250	0	250	169,172	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,965	0	10,965	1,232,954	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	94,481	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,855	0	8,855	890,544	0
60.00	06000	LABORATORY	3,212	0	3,926	962,032	0
65.00	06500	RESPIRATORY THERAPY	4,089	0	4,089	539,439	0
66.00	06600	PHYSICAL THERAPY	3,475	0	3,475	494,831	0
67.00	06700	OCCUPATIONAL THERAPY	100	0	100	112,917	0
68.00	06800	SPEECH PATHOLOGY	50	0	50	99,546	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03020	OP PSYCH	0	0	0	194,898	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	4,386	219,174	0
90.01	09001	CLINIC - AMO	0	0	1,955	330,710	0
90.02	09002	CLINIC - AMH NEURO	0	0	0	8,381	0
90.03	09003	CLINIC - NIGLIAZZO	0	0	2,325	209,523	0
91.00	09100	EMERGENCY	5,407	0	5,407	931,127	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	4,323	1,036,116	0
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	115,504	0	138,275	14,429,256	-7,619,349
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	654	0	654	0	0
194.00	07950	TITLE XX	0	0	0	0	0
194.01	07951	OTHER NRCC	3,147	0	6,951	717,079	0
194.02	07952	OTHER MOBS	0	0	0	0	0
194.03	07953	MONROE	0	0	1,714	353,020	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per wkst. B, Part I)	2,552,133	0	83,466	4,607,618	202.00
203.00		Unit cost multiplier (wkst. B, Part I)	21.391668	0.000000	0.565511	0.297278	203.00
204.00		Cost to be allocated (per wkst. B, Part II)				0	204.00
205.00		Unit cost multiplier (wkst. B, Part II)				0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151330

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

Worksheet B-1

Date/Time Prepared:
5/29/2014 6:49 pm

Cost Center Description			ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	BIO-MEDICAL (COST)	UTILITIES - HOSPITAL (SQUARE FEET)	UTILITIES - OFFSITE BLDGS (COST)	
			5.00	7.00	7.01	7.02	7.03	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OTHER CAP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	30,839,606					5.00
7.00	00700	OPERATION OF PLANT	1,634,471	105,834				7.00
7.01	00701	BIO-MEDICAL	191,769	436	13,235,077			7.01
7.02	00702	UTILITIES - HOSPITAL	561,569	0	0	85,778		7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	100,783	0	0	0	100,784	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	214,934	1,729	0	1,729	0	8.00
9.00	00900	HOUSEKEEPING	633,362	2,753	0	2,354	0	9.00
10.00	01000	DIETARY	245,656	700	0	700	0	10.00
11.00	01100	CAFETERIA	933,938	6,254	0	6,254	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,198,969	587	0	587	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	705	0	0	0	0	14.00
15.00	01500	PHARMACY	965,745	1,585	0	1,585	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	789,012	2,539	0	2,539	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,882,225	19,453	2,240,138	19,453	0	30.00
31.00	03100	INTENSIVE CARE UNIT	815,011	3,224	54,344	3,224	0	31.00
40.00	04000	SUBPROVIDER - IPF	1,047,588	7,149	4,306	7,149	0	40.00
43.00	04300	NURSERY	238,118	250	17,701	250	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,304,545	10,965	3,461,753	10,965	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	129,921	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,048,866	8,855	5,595,678	8,855	0	54.00
60.00	06000	LABORATORY	2,782,541	3,926	580,068	3,212	0	60.00
65.00	06500	RESPIRATORY THERAPY	789,899	4,089	665,982	4,089	0	65.00
66.00	06600	PHYSICAL THERAPY	760,498	3,475	262,604	3,475	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	160,864	100	0	100	0	67.00
68.00	06800	SPEECH PATHOLOGY	139,289	50	0	50	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	958,017	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	343,761	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,481,820	0	0	0	0	73.00
76.00	03020	OP PSYCH	291,548	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	403,076	4,386	5,551	0	0	90.00
90.01	09001	CLINIC - AMO	470,345	1,955	0	0	6,091	90.01
90.02	09002	CLINIC - AMH NEURO	16,665	0	24,275	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	320,731	2,325	0	0	0	90.03
91.00	09100	EMERGENCY	1,613,531	5,407	70,226	5,407	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,489,385	4,323	223,355	0	7,984	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	28,958,452	96,515	13,205,981	81,977	14,075	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,360	654	0	654	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	1,148,893	6,951	29,096	3,147	12,327	194.01
194.02	07952	OTHER MOBS	193,649	0	0	0	74,382	194.02
194.03	07953	MONROE	524,252	1,714	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,619,349	2,038,290	247,545	700,312	125,683	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.247064	19.259312	0.018704	8.164238	1.247053	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	390,641	423,025	13,746	7,113	1,277	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.012667	3.997061	0.001039	0.082923	0.012671	205.00

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
7.01	00701						7.01
7.02	00702						7.02
7.03	00703						7.03
8.00	00800						8.00
9.00	00900	197,988	100,916				9.00
10.00	01000	34,661	700	21,645			10.00
11.00	01100	1,630					11.00
13.00	01300	8,410	6,254	0	503,987		13.00
14.00	01400	0	587	0	23,692	190,313	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	1,585	0	14,220	0	16.00
		0	2,539	0	15,030	0	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	33,371	19,453	13,965	75,757	75,757	30.00
31.00	03100	8,842	3,224	2,421	19,428	19,428	31.00
40.00	04000	6,283	7,149	5,259	28,995	28,995	40.00
43.00	04300	0	250	0	5,468	5,468	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	30,879	10,965	0	33,823	33,823	50.00
52.00	05200	5,075	0	0	3,054	3,054	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	15,086	8,855	0	33,208	0	54.00
60.00	06000	156	3,926	0	44,155	0	60.00
65.00	06500	6,068	4,089	0	22,899	0	65.00
66.00	06600	10,552	3,475	0	28,339	0	66.00
67.00	06700	0	100	0	14,342	0	67.00
68.00	06800	0	50	0	3,967	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03020	1,824	0	0	8,417	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	1,133	4,386	0	17,134	0	90.00
90.01	09001	43	1,955	0	10,721	0	90.01
90.02	09002	6	0	0	373	0	90.02
90.03	09003	274	2,325	0	8,218	0	90.03
91.00	09100	23,140	5,407	0	23,788	23,788	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	9,284	4,323	0	49,725	0	95.00
97.00	09700	0	0	0	0	0	97.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	0	0	0	116.00
118.00		196,717	91,597	21,645	484,753	190,313	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	654	0	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	889	6,951	0	19,234	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	382	1,714	0	0	0	194.03
200.00							200.00
201.00							201.00
202.00		315,451	917,306	334,506	1,406,435	1,582,739	202.00
203.00		1.593283	9.089797	15.454193	2.790618	8.316505	203.00
204.00		47,741	79,493	22,282	181,621	39,471	204.00
205.00		0.241131	0.787715	1.029429	0.360368	0.207400	205.00

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201 OTHER CAP				2.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500 ADMINISTRATIVE & GENERAL				5.00
7.00	00700 OPERATION OF PLANT				7.00
7.01	00701 BIO-MEDICAL				7.01
7.02	00702 UTILITIES - HOSPITAL				7.02
7.03	00703 UTILITIES - OFFSITE BLDGS				7.03
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00	00900 HOUSEKEEPING				9.00
10.00	01000 DIETARY				10.00
11.00	01100 CAFETERIA				11.00
13.00	01300 NURSING ADMINISTRATION				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0			14.00
15.00	01500 PHARMACY	0	100		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	950,202	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	0	0	292,929	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	24,874	31.00
40.00	04000 SUBPROVIDER - IPF	0	0	60,494	40.00
43.00	04300 NURSERY	0	0	2,005	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	77,453	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	10,860	54.00
60.00	06000 LABORATORY	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	6,132	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	100	0	73.00
76.00	03020 OP PSYCH	0	0	17,563	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	5,482	90.00
90.01	09001 CLINIC - AMO	0	0	9,065	90.01
90.02	09002 CLINIC - AMH NEURO	0	0	2,113	90.02
90.03	09003 CLINIC - NIGLIAZZO	0	0	7,167	90.03
91.00	09100 EMERGENCY	0	0	428,235	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0	0	0	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	97.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600 HOSPICE	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	100	944,372	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
194.00	07950 TITLE XX	0	0	0	194.00
194.01	07951 OTHER NRCC	0	0	2,915	194.01
194.02	07952 OTHER MOBS	0	0	0	194.02
194.03	07953 MONROE	0	0	2,915	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)	0	1,301,902	1,118,598	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	13,019.020000	1.177221	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	59,874	83,519	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	598.740000	0.087896	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151330

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2014 6:49 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Hospital		Total Costs	
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	5,801,778		5,801,778	0	5,801,778	30.00
31.00	03100 INTENSIVE CARE UNIT	1,431,681		1,431,681	0	1,431,681	31.00
40.00	04000 SUBPROVIDER - IPF	2,052,075		2,052,075	0	2,052,075	40.00
43.00	04300 NURSERY	369,501		369,501	0	369,501	43.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	3,855,087		3,855,087	0	3,855,087	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	204,028		204,028	0	204,028	52.00
53.00	05300 ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,112,539		3,112,539	0	3,112,539	54.00
60.00	06000 LABORATORY	3,741,849		3,741,849	0	3,741,849	60.00
65.00	06500 RESPIRATORY THERAPY	1,227,604	0	1,227,604	0	1,227,604	65.00
66.00	06600 PHYSICAL THERAPY	1,176,081	0	1,176,081	0	1,176,081	66.00
67.00	06700 OCCUPATIONAL THERAPY	244,282	0	244,282	0	244,282	67.00
68.00	06800 SPEECH PATHOLOGY	186,597	0	186,597	0	186,597	68.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,194,709		1,194,709	0	1,194,709	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	428,692		428,692	0	428,692	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,149,826		3,149,826	0	3,149,826	73.00
76.00	03020 OP PSYCH	410,650		410,650	0	410,650	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	683,178		683,178	0	683,178	90.00
90.01	09001 CLINIC - AMO	690,228		690,228	0	690,228	90.01
90.02	09002 CLINIC - AMH NEURO	24,774		24,774	0	24,774	90.02
90.03	09003 CLINIC - NIGLIAZZO	497,691		497,691	0	497,691	90.03
91.00	09100 EMERGENCY	3,016,129		3,016,129	0	3,016,129	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	836,288		836,288	0	836,288	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	2,147,600		2,147,600	0	2,147,600	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97.00
101.00	10100 HOME HEALTH AGENCY	0		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600 HOSPICE	0		0	0	0	116.00
200.00	Subtotal (see instructions)	36,482,867	0	36,482,867	0	36,482,867	200.00
201.00	Less Observation Beds	836,288		836,288		836,288	201.00
202.00	Total (see instructions)	35,646,579	0	35,646,579	0	35,646,579	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151330

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2014 6:49 pm

		Title XVIII			Hospital	Cost	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,139,675		5,139,675		30.00
31.00	03100	INTENSIVE CARE UNIT	1,705,855		1,705,855		31.00
40.00	04000	SUBPROVIDER - IPF	2,405,589		2,405,589		40.00
43.00	04300	NURSERY	245,189		245,189		43.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,680,899	4,488,964	6,169,863	0.624825	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	136,934	58,512	195,446	1.043910	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,904,243	14,615,626	16,519,869	0.188412	54.00
60.00	06000	LABORATORY	2,899,238	12,523,828	15,423,066	0.242614	60.00
65.00	06500	RESPIRATORY THERAPY	3,084,298	2,200,246	5,284,544	0.232301	65.00
66.00	06600	PHYSICAL THERAPY	240,170	1,907,280	2,147,450	0.547664	66.00
67.00	06700	OCCUPATIONAL THERAPY	110,435	272,648	383,083	0.637674	67.00
68.00	06800	SPEECH PATHOLOGY	82,959	300,538	383,497	0.486567	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,396,197	1,008,127	2,404,324	0.496900	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	698,147	179,609	877,756	0.488395	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,815,961	4,678,796	8,494,757	0.370796	73.00
76.00	03020	OP PSYCH	0	698,339	698,339	0.588038	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	1,471,962	1,471,962	0.464127	90.00
90.01	09001	CLINIC - AMO	0	2,423,568	2,423,568	0.284798	90.01
90.02	09002	CLINIC - AMH NEURO	0	566,532	566,532	0.043729	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	1,924,067	1,924,067	0.258666	90.03
91.00	09100	EMERGENCY	187,300	2,867,259	3,054,559	0.987419	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,227,857	1,227,857	0.681096	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	2,866,773	2,866,773	0.749135	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0		116.00
200.00		Subtotal (see instructions)	25,733,089	56,280,531	82,013,620		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	25,733,089	56,280,531	82,013,620		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151330

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2014 6:49 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.624825		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.043910		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.188412		54.00
60.00	06000	LABORATORY	0.242614		60.00
65.00	06500	RESPIRATORY THERAPY	0.232301		65.00
66.00	06600	PHYSICAL THERAPY	0.547664		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.637674		67.00
68.00	06800	SPEECH PATHOLOGY	0.486567		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.496900		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.488395		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.370796		73.00
76.00	03020	OP PSYCH	0.588038		76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.464127		90.00
90.01	09001	CLINIC - AMO	0.284798		90.01
90.02	09002	CLINIC - AMH NEURO	0.043729		90.02
90.03	09003	CLINIC - NIGLIAZZO	0.258666		90.03
91.00	09100	EMERGENCY	0.987419		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.681096		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.749135		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000		97.00
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151330

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2014 6:49 pm

		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	5,801,778	5,801,778	0	5,801,778	30.00
31.00	03100 INTENSIVE CARE UNIT	1,431,681	1,431,681	0	1,431,681	31.00
40.00	04000 SUBPROVIDER - IPF	2,052,075	2,052,075	0	2,052,075	40.00
43.00	04300 NURSERY	369,501	369,501	0	369,501	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3,855,087	3,855,087	0	3,855,087	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	204,028	204,028	0	204,028	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,112,539	3,112,539	0	3,112,539	54.00
60.00	06000 LABORATORY	3,741,849	3,741,849	0	3,741,849	60.00
65.00	06500 RESPIRATORY THERAPY	1,227,604	1,227,604	0	1,227,604	65.00
66.00	06600 PHYSICAL THERAPY	1,176,081	1,176,081	0	1,176,081	66.00
67.00	06700 OCCUPATIONAL THERAPY	244,282	244,282	0	244,282	67.00
68.00	06800 SPEECH PATHOLOGY	186,597	186,597	0	186,597	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,194,709	1,194,709	0	1,194,709	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	428,692	428,692	0	428,692	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,149,826	3,149,826	0	3,149,826	73.00
76.00	03020 OP PSYCH	410,650	410,650	0	410,650	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	683,178	683,178	0	683,178	90.00
90.01	09001 CLINIC - AMO	690,228	690,228	0	690,228	90.01
90.02	09002 CLINIC - AMH NEURO	24,774	24,774	0	24,774	90.02
90.03	09003 CLINIC - NIGLIAZZO	497,691	497,691	0	497,691	90.03
91.00	09100 EMERGENCY	3,016,129	3,016,129	0	3,016,129	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	836,288	836,288	0	836,288	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	2,147,600	2,147,600	0	2,147,600	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600 HOSPICE	0	0	0	0	116.00
200.00	Subtotal (see instructions)	36,482,867	36,482,867	0	36,482,867	200.00
201.00	Less Observation Beds	836,288	836,288	0	836,288	201.00
202.00	Total (see instructions)	35,646,579	35,646,579	0	35,646,579	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151330

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2014 6:49 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XIX Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,139,675		5,139,675		30.00
31.00	03100	INTENSIVE CARE UNIT	1,705,855		1,705,855		31.00
40.00	04000	SUBPROVIDER - IPF	2,405,589		2,405,589		40.00
43.00	04300	NURSERY	245,189		245,189		43.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,680,899	4,488,964	6,169,863	0.624825	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	136,934	58,512	195,446	1.043910	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,904,243	14,615,626	16,519,869	0.188412	54.00
60.00	06000	LABORATORY	2,899,238	12,523,828	15,423,066	0.242614	60.00
65.00	06500	RESPIRATORY THERAPY	3,084,298	2,200,246	5,284,544	0.232301	65.00
66.00	06600	PHYSICAL THERAPY	240,170	1,907,280	2,147,450	0.547664	66.00
67.00	06700	OCCUPATIONAL THERAPY	110,435	272,648	383,083	0.637674	67.00
68.00	06800	SPEECH PATHOLOGY	82,959	300,538	383,497	0.486567	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,396,197	1,008,127	2,404,324	0.496900	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	698,147	179,609	877,756	0.488395	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,815,961	4,678,796	8,494,757	0.370796	73.00
76.00	03020	OP PSYCH	0	698,339	698,339	0.588038	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	1,471,962	1,471,962	0.464127	90.00
90.01	09001	CLINIC - AMO	0	2,423,568	2,423,568	0.284798	90.01
90.02	09002	CLINIC - AMH NEURO	0	566,532	566,532	0.043729	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	1,924,067	1,924,067	0.258666	90.03
91.00	09100	EMERGENCY	187,300	2,867,259	3,054,559	0.987419	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,227,857	1,227,857	0.681096	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	2,866,773	2,866,773	0.749135	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0		116.00
200.00		Subtotal (see instructions)	25,733,089	56,280,531	82,013,620		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	25,733,089	56,280,531	82,013,620		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151330	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/29/2014 6:49 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital
		11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.624825	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.043910	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.188412	54.00
60.00	06000	LABORATORY	0.242614	60.00
65.00	06500	RESPIRATORY THERAPY	0.232301	65.00
66.00	06600	PHYSICAL THERAPY	0.547664	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.637674	67.00
68.00	06800	SPEECH PATHOLOGY	0.486567	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.496900	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.488395	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.370796	73.00
76.00	03020	OP PSYCH	0.588038	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.464127	90.00
90.01	09001	CLINIC - AMO	0.284798	90.01
90.02	09002	CLINIC - AMH NEURO	0.043729	90.02
90.03	09003	CLINIC - NIGLIAZZO	0.258666	90.03
91.00	09100	EMERGENCY	0.987419	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.681096	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0.749135	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	97.00
101.00	10100	HOME HEALTH AGENCY		101.00
SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 151330

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

Worksheet C
Part II
Date/Time Prepared:
5/29/2014 6:49 pm

Cost Center Description		Title XIX			Hospital		PPS	
		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	3,855,087	360,382	3,494,705	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	204,028	4,604	199,424	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,112,539	285,856	2,826,683	0	0	54.00
60.00	06000	LABORATORY	3,741,849	141,780	3,600,069	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,227,604	130,639	1,096,965	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,176,081	115,878	1,060,203	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	244,282	9,889	234,393	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	186,597	4,535	182,062	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,194,709	12,135	1,182,574	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	428,692	4,354	424,338	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,149,826	78,644	3,071,182	0	0	73.00
76.00	03020	OP PSYCH	410,650	8,710	401,940	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	683,178	35,508	647,670	0	0	90.00
90.01	09001	CLINIC - AMO	690,228	21,166	669,062	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	24,774	557	24,217	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	497,691	20,160	477,531	0	0	90.03
91.00	09100	EMERGENCY	3,016,129	222,280	2,793,849	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	836,288	0	836,288	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	2,147,600	62,486	2,085,114	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	26,827,832	1,519,563	25,308,269	0	0	200.00
201.00		Less Observation Beds	836,288	0	836,288	0	0	201.00
202.00		Total (line 200 minus line 201)	25,991,544	1,519,563	24,471,981	0	0	202.00

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

Provider CCN: 151330

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

Worksheet C
Part II
Date/Time Prepared:
5/29/2014 6:49 pm

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	3,855,087	6,169,863	0.624825	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	204,028	195,446	1.043910	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,112,539	16,519,869	0.188412	54.00
60.00	06000 LABORATORY	3,741,849	15,423,066	0.242614	60.00
65.00	06500 RESPIRATORY THERAPY	1,227,604	5,284,544	0.232301	65.00
66.00	06600 PHYSICAL THERAPY	1,176,081	2,147,450	0.547664	66.00
67.00	06700 OCCUPATIONAL THERAPY	244,282	383,083	0.637674	67.00
68.00	06800 SPEECH PATHOLOGY	186,597	383,497	0.486567	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,194,709	2,404,324	0.496900	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	428,692	877,756	0.488395	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,149,826	8,494,757	0.370796	73.00
76.00	03020 OP PSYCH	410,650	698,339	0.588038	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	683,178	1,471,962	0.464127	90.00
90.01	09001 CLINIC - AMO	690,228	2,423,568	0.284798	90.01
90.02	09002 CLINIC - AMH NEURO	24,774	566,532	0.043729	90.02
90.03	09003 CLINIC - NYGLIAZZO	497,691	1,924,067	0.258666	90.03
91.00	09100 EMERGENCY	3,016,129	3,054,559	0.987419	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	836,288	1,227,857	0.681096	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	2,147,600	2,866,773	0.749135	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	97.00
101.00	10100 HOME HEALTH AGENCY	0	0	0.000000	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600 HOSPICE	0	0	0.000000	116.00
200.00	Subtotal (sum of lines 50 thru 199)	26,827,832	72,517,312		200.00
201.00	Less Observation Beds	836,288	0		201.00
202.00	Total (line 200 minus line 201)	25,991,544	72,517,312		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151330	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/29/2014 6:49 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital 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	360,382	6,169,863	0.058410	188,081	10,986	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4,604	195,446	0.023556	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	285,856	16,519,869	0.017304	554,087	9,588	54.00
60.00	06000 LABORATORY	141,780	15,423,066	0.009193	1,210,077	11,124	60.00
65.00	06500 RESPIRATORY THERAPY	130,639	5,284,544	0.024721	1,384,791	34,233	65.00
66.00	06600 PHYSICAL THERAPY	115,878	2,147,450	0.053961	129,326	6,979	66.00
67.00	06700 OCCUPATIONAL THERAPY	9,889	383,083	0.025814	57,778	1,491	67.00
68.00	06800 SPEECH PATHOLOGY	4,535	383,497	0.011825	42,851	507	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12,135	2,404,324	0.005047	1,287,171	6,496	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	4,354	877,756	0.004960	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	78,644	8,494,757	0.009258	1,545,856	14,312	73.00
76.00	03020 OP PSYCH	8,710	698,339	0.012472	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	35,508	1,471,962	0.024123	0	0	90.00
90.01	09001 CLINIC - AMO	21,166	2,423,568	0.008733	0	0	90.01
90.02	09002 CLINIC - AMH NEURO	557	566,532	0.000983	0	0	90.02
90.03	09003 CLINIC - NIGLIAZZO	20,160	1,924,067	0.010478	0	0	90.03
91.00	09100 EMERGENCY	222,280	3,054,559	0.072770	6,173	449	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,227,857	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
200.00	Total (lines 50-199)	1,457,077	69,650,539		6,406,191	96,165	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2014 6:49 pm

Cost Center Description		Title XVIII			Hospital	Cost	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	OP PSYCH	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151330	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/29/2014 6:49 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. c, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Cost
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	6,169,863	0.000000	0.000000	188,081	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	195,446	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	16,519,869	0.000000	0.000000	554,087	54.00
60.00	06000 LABORATORY	0	15,423,066	0.000000	0.000000	1,210,077	60.00
65.00	06500 RESPIRATORY THERAPY	0	5,284,544	0.000000	0.000000	1,384,791	65.00
66.00	06600 PHYSICAL THERAPY	0	2,147,450	0.000000	0.000000	129,326	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	383,083	0.000000	0.000000	57,778	67.00
68.00	06800 SPEECH PATHOLOGY	0	383,497	0.000000	0.000000	42,851	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,404,324	0.000000	0.000000	1,287,171	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	877,756	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	8,494,757	0.000000	0.000000	1,545,856	73.00
76.00	03020 OP PSYCH	0	698,339	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	1,471,962	0.000000	0.000000	0	90.00
90.01	09001 CLINIC - AMO	0	2,423,568	0.000000	0.000000	0	90.01
90.02	09002 CLINIC - AMH NEURO	0	566,532	0.000000	0.000000	0	90.02
90.03	09003 CLINIC - NIGLIAZZO	0	1,924,067	0.000000	0.000000	0	90.03
91.00	09100 EMERGENCY	0	3,054,559	0.000000	0.000000	6,173	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,227,857	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0.000000	0	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0.000000	0	97.00
200.00	Total (lines 50-199)	0	69,650,539			6,406,191	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2014 6:49 pm

Cost Center Description		Title XVIII			Hospital		Cost
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	OP PSYCH	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2014 6:49 pm

Cost Center Description		Title XVIII		Hospital	Cost
		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
		23.00	24.00		
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000 LABORATORY	0	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020 OP PSYCH	0	0		76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0		90.00
90.01	09001 CLINIC - AMO	0	0		90.01
90.02	09002 CLINIC - AMH NEURO	0	0		90.02
90.03	09003 CLINIC - NIGLIAZZO	0	0		90.03
91.00	09100 EMERGENCY	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0	0		95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
200.00	Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151330		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part V Date/Time Prepared: 5/29/2014 6:49 pm	
		Title XVIII		Hospital		Cost	
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Charges		Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.624825	0	1,221,130	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.043910	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.188412	0	2,831,573	0	0	54.00
60.00	06000 LABORATORY	0.242614	0	1,252,590	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.232301	0	1,097,887	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.547664	0	479,865	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.637674	0	38,141	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.486567	0	26,743	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.496900	0	375,542	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.488395	0	49,731	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.370796	0	1,299,490	251	0	73.00
76.00	03020 OP PSYCH	0.588038	0	35,864	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.464127	0	43,304	0	0	90.00
90.01	09001 CLINIC - AMO	0.284798	0	71,299	210	0	90.01
90.02	09002 CLINIC - AMH NEURO	0.043729	0	16,667	0	0	90.02
90.03	09003 CLINIC - NIGLIAZZO	0.258666	0	56,604	0	0	90.03
91.00	09100 EMERGENCY	0.987419	0	632,781	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.681096	0	171,549	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0.749135	0	0	0	0	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
200.00	Subtotal (see instructions)		0	9,700,760	461	0	200.00
201.00	Less PBP Clinic Lab. Services-Program only Charges			0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	9,700,760	461	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151330	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/29/2014 6:49 pm
		Title XVIII	Hospital	Cost

Cost Center Description	Costs		Hospital	Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	762,993	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	533,502	0		54.00
60.00 06000 LABORATORY	303,896	0		60.00
65.00 06500 RESPIRATORY THERAPY	255,040	0		65.00
66.00 06600 PHYSICAL THERAPY	262,805	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	24,322	0		67.00
68.00 06800 SPEECH PATHOLOGY	13,012	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	186,607	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	24,288	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	481,846	93		73.00
76.00 03020 OP PSYCH	21,089	0		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	20,099	0		90.00
90.01 09001 CLINIC - AMO	20,306	60		90.01
90.02 09002 CLINIC - AMH NEURO	729	0		90.02
90.03 09003 CLINIC - NIGLIAZZO	14,642	0		90.03
91.00 09100 EMERGENCY	624,820	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	116,841	0		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES	0	0		95.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
200.00 Subtotal (see instructions)	3,666,837	153		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0		201.00
202.00 Net Charges (line 200 +/- line 201)	3,666,837	153		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151330	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/29/2014 6:49 pm		
		Component CCN: 15M330	Title XVIII	Subprovider - IPF	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	360,382	6,169,863	0.058410	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4,604	195,446	0.023556	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	285,856	16,519,869	0.017304	13,312	54.00
60.00	06000 LABORATORY	141,780	15,423,066	0.009193	63,700	60.00
65.00	06500 RESPIRATORY THERAPY	130,639	5,284,544	0.024721	15,200	65.00
66.00	06600 PHYSICAL THERAPY	115,878	2,147,450	0.053961	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	9,889	383,083	0.025814	539	67.00
68.00	06800 SPEECH PATHOLOGY	4,535	383,497	0.011825	547	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12,135	2,404,324	0.005047	14,626	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	4,354	877,756	0.004960	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	78,644	8,494,757	0.009258	94,435	73.00
76.00	03020 OP PSYCH	8,710	698,339	0.012472	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	35,508	1,471,962	0.024123	0	90.00
90.01	09001 CLINIC - AMO	21,166	2,423,568	0.008733	0	90.01
90.02	09002 CLINIC - AMH NEURO	557	566,532	0.000983	0	90.02
90.03	09003 CLINIC - NIGLIAZZO	20,160	1,924,067	0.010478	0	90.03
91.00	09100 EMERGENCY	222,280	3,054,559	0.072770	175	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,227,857	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	97.00
200.00	Total (Lines 50-199)	1,457,077	69,650,539		202,534	2,173

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330
Component CCN: 15M330

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2014 6:49 pm

Title XVIII

Subprovider -
IPF

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
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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 PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020 OP PSYCH	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 CLINIC - AMO	0	0	0	0	0	90.01
90.02	09002 CLINIC - AMH NEURO	0	0	0	0	0	90.02
90.03	09003 CLINIC - NIGLIAZZO	0	0	0	0	0	90.03
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
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
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: 151330 Component CCN: 15M330		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part IV Date/Time Prepared: 5/29/2014 6:49 pm	
Title XVIII				Subprovider - IPF		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	6,169,863	0.000000	0.000000	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	195,446	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	16,519,869	0.000000	0.000000	13,312	54.00
60.00	06000 LABORATORY	0	15,423,066	0.000000	0.000000	63,700	60.00
65.00	06500 RESPIRATORY THERAPY	0	5,284,544	0.000000	0.000000	15,200	65.00
66.00	06600 PHYSICAL THERAPY	0	2,147,450	0.000000	0.000000	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	383,083	0.000000	0.000000	539	67.00
68.00	06800 SPEECH PATHOLOGY	0	383,497	0.000000	0.000000	547	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,404,324	0.000000	0.000000	14,626	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	877,756	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	8,494,757	0.000000	0.000000	94,435	73.00
76.00	03020 OP PSYCH	0	698,339	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	1,471,962	0.000000	0.000000	0	90.00
90.01	09001 CLINIC - AMO	0	2,423,568	0.000000	0.000000	0	90.01
90.02	09002 CLINIC - AMH NEURO	0	566,532	0.000000	0.000000	0	90.02
90.03	09003 CLINIC - NIGLIAZZO	0	1,924,067	0.000000	0.000000	0	90.03
91.00	09100 EMERGENCY	0	3,054,559	0.000000	0.000000	175	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,227,857	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0.000000	0	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0.000000	0	97.00
200.00	Total (lines 50-199)	0	69,650,539			202,534	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330
Component CCN: 15M330

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2014 6:49 pm

Title XVIII

Subprovider -
IPF

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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	OP PSYCH	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151330 Component CCN: 15M330	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/29/2014 6:49 pm
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020 OP PSYCH	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
90.01	09001 CLINIC - AMO	0	0	90.01
90.02	09002 CLINIC - AMH NEURO	0	0	90.02
90.03	09003 CLINIC - NIGLIAZZO	0	0	90.03
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES			95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151330	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/29/2014 6:49 pm
		Component CCN: 15Z330	Title XVIII	Swing Beds - SNF

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost	
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.624825	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.043910	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.188412	0	0	0	0	54.00
60.00	06000 LABORATORY	0.242614	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.232301	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.547664	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.637674	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.486567	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	0.496900	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.488395	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.370796	0	0	0	0	73.00
76.00	03020 OP PSYCH	0.588038	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.464127	0	0	0	0	90.00
90.01	09001 CLINIC - AMO	0.284798	0	0	0	0	90.01
90.02	09002 CLINIC - AMH NEURO	0.043729	0	0	0	0	90.02
90.03	09003 CLINIC - NIGLIAZZO	0.258666	0	0	0	0	90.03
91.00	09100 EMERGENCY	0.987419	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.681096	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0.749135	0	0	0	0	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
200.00	Subtotal (see instructions)		0	0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151330

Period: From 01/01/2013

Worksheet D

Component CCN: 152330

To 12/31/2013

Part V

Date/Time Prepared: 5/29/2014 6:49 pm

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020	OP PSYCH	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	90.03
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00		Net Charges (Line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151330	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part I Date/Time Prepared: 5/29/2014 6:49 pm
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Cost Center Description	Title XIX			Hospital	PPS
	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	651,843	0	651,843	5,308	122.80	30.00
31.00	INTENSIVE CARE UNIT	114,704		114,704	807	142.14	31.00
40.00	SUBPROVIDER - IPF	233,754	0	233,754	1,753	133.35	40.00
43.00	NURSERY	13,020		13,020	384	33.91	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30-199)	1,013,321		1,013,321	8,252		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	295	36,226				30.00
31.00	INTENSIVE CARE UNIT	30	4,264				31.00
40.00	SUBPROVIDER - IPF	346	46,139				40.00
43.00	NURSERY	47	1,594				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30-199)	718	88,223				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 151330		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part II Date/Time Prepared: 5/29/2014 6:49 pm	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	PPS
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	360,382	6,169,863	0.058410	73,321	4,283	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,604	195,446	0.023556	35,650	840	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	285,856	16,519,869	0.017304	68,845	1,191	54.00
60.00	06000	LABORATORY	141,780	15,423,066	0.009193	170,907	1,571	60.00
65.00	06500	RESPIRATORY THERAPY	130,639	5,284,544	0.024721	112,507	2,781	65.00
66.00	06600	PHYSICAL THERAPY	115,878	2,147,450	0.053961	3,278	177	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,889	383,083	0.025814	2,336	60	67.00
68.00	06800	SPEECH PATHOLOGY	4,535	383,497	0.011825	924	11	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,135	2,404,324	0.005047	92,271	466	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,354	877,756	0.004960	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	78,644	8,494,757	0.009258	249,622	2,311	73.00
76.00	03020	OP PSYCH	8,710	698,339	0.012472	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	35,508	1,471,962	0.024123	0	0	90.00
90.01	09001	CLINIC - AMO	21,166	2,423,568	0.008733	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	557	566,532	0.000983	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	20,160	1,924,067	0.010478	0	0	90.03
91.00	09100	EMERGENCY	222,280	3,054,559	0.072770	4,478	326	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	94,068	1,227,857	0.076612	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
200.00		Total (lines 50-199)	1,551,145	69,650,539		814,139	14,017	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151330	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part III Date/Time Prepared: 5/29/2014 6:49 pm
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Cost Center Description	Title XIX				Hospital	PPS
	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	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
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)	PSA Adj. Nursing School
	6.00	7.00	8.00	9.00	11.00

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,308	0.00	295	0	30.00
31.00	03100	INTENSIVE CARE UNIT	807	0.00	30	0	31.00
40.00	04000	SUBPROVIDER - IPF	1,753	0.00	346	0	40.00
43.00	04300	NURSERY	384	0.00	47	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0	44.00
200.00		Total (lines 30-199)	8,252		718	0	200.00

Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost
	12.00	13.00

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0			30.00
31.00	03100	INTENSIVE CARE UNIT	0	0			31.00
40.00	04000	SUBPROVIDER - IPF	0	0			40.00
43.00	04300	NURSERY	0	0			43.00
44.00	04400	SKILLED NURSING FACILITY	0	0			44.00
200.00		Total (lines 30-199)	0	0			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2014 6:49 pm

Cost Center Description		Title XIX			Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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 PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OP PSYCH	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0	0	0	90.03
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
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
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: 151330

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2014 6:49 pm

Cost Center Description		Title XIX			Hospital		PPS	
		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	6,169,863	0.000000	0.000000	73,321	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	195,446	0.000000	0.000000	35,650	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,519,869	0.000000	0.000000	68,845	54.00
60.00	06000	LABORATORY	0	15,423,066	0.000000	0.000000	170,907	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,284,544	0.000000	0.000000	112,507	65.00
66.00	06600	PHYSICAL THERAPY	0	2,147,450	0.000000	0.000000	3,278	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	383,083	0.000000	0.000000	2,336	67.00
68.00	06800	SPEECH PATHOLOGY	0	383,497	0.000000	0.000000	924	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,404,324	0.000000	0.000000	92,271	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	877,756	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,494,757	0.000000	0.000000	249,622	73.00
76.00	03020	OP PSYCH	0	698,339	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,471,962	0.000000	0.000000	0	90.00
90.01	09001	CLINIC - AMO	0	2,423,568	0.000000	0.000000	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	566,532	0.000000	0.000000	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	1,924,067	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	3,054,559	0.000000	0.000000	4,478	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,227,857	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0.000000	0	97.00
200.00		Total (lines 50-199)	0	69,650,539			814,139	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151330	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/29/2014 6:49 pm
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Cost Center Description		Title XIX			Hospital		
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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 PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020 OP PSYCH	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 CLINIC - AMO	0	0	0	0	0	90.01
90.02	09002 CLINIC - AMH NEURO	0	0	0	0	0	90.02
90.03	09003 CLINIC - NIGLIAZZO	0	0	0	0	0	90.03
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
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
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: 151330

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2014 6:49 pm

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XIX	Hospital	PPS
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			52.00
53.00	05300 ANESTHESIOLOGY	0	0			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0			54.00
60.00	06000 LABORATORY	0	0			60.00
65.00	06500 RESPIRATORY THERAPY	0	0			65.00
66.00	06600 PHYSICAL THERAPY	0	0			66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0			67.00
68.00	06800 SPEECH PATHOLOGY	0	0			68.00
69.00	06900 ELECTROCARDIOLOGY	0	0			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			73.00
76.00	03020 OP PSYCH	0	0			76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0			90.00
90.01	09001 CLINIC - AMO	0	0			90.01
90.02	09002 CLINIC - AMH NEURO	0	0			90.02
90.03	09003 CLINIC - NIGLIAZZO	0	0			90.03
91.00	09100 EMERGENCY	0	0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0			97.00
200.00	Total (lines 50-199)	0	0			200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151330 Component CCN: 15M330	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/29/2014 6:49 pm
		Title XIX	Subprovider - IPF	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	360,382	6,169,863	0.058410	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4,604	195,446	0.023556	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	285,856	16,519,869	0.017304	750	13	54.00
60.00	06000 LABORATORY	141,780	15,423,066	0.009193	29,830	274	60.00
65.00	06500 RESPIRATORY THERAPY	130,639	5,284,544	0.024721	8,059	199	65.00
66.00	06600 PHYSICAL THERAPY	115,878	2,147,450	0.053961	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	9,889	383,083	0.025814	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	4,535	383,497	0.011825	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12,135	2,404,324	0.005047	2,125	11	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	4,354	877,756	0.004960	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	78,644	8,494,757	0.009258	49,242	456	73.00
76.00	03020 OP PSYCH	8,710	698,339	0.012472	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	35,508	1,471,962	0.024123	0	0	90.00
90.01	09001 CLINIC - AMO	21,166	2,423,568	0.008733	0	0	90.01
90.02	09002 CLINIC - AMH NEURO	557	566,532	0.000983	0	0	90.02
90.03	09003 CLINIC - NIGLIAZZO	20,160	1,924,067	0.010478	0	0	90.03
91.00	09100 EMERGENCY	222,280	3,054,559	0.072770	286	21	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,227,857	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
200.00	Total (lines 50-199)	1,457,077	69,650,539		90,292	974	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330
Component CCN: 15M330

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2014 6:49 pm
PPS

Title XIX

Subprovider -
IPF

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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 PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020 OP PSYCH	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 CLINIC - AMO	0	0	0	0	0	90.01
90.02	09002 CLINIC - AMH NEURO	0	0	0	0	0	90.02
90.03	09003 CLINIC - NIGLIAZZO	0	0	0	0	0	90.03
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
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
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: 151330
Component CCN: 15M330

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2014 6:49 pm
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	6,169,863	0.000000	0.000000	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	195,446	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	16,519,869	0.000000	0.000000	750	54.00
60.00	06000 LABORATORY	0	15,423,066	0.000000	0.000000	29,830	60.00
65.00	06500 RESPIRATORY THERAPY	0	5,284,544	0.000000	0.000000	8,059	65.00
66.00	06600 PHYSICAL THERAPY	0	2,147,450	0.000000	0.000000	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	383,083	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	383,497	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,404,324	0.000000	0.000000	2,125	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	877,756	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	8,494,757	0.000000	0.000000	49,242	73.00
76.00	03020 OP PSYCH	0	698,339	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	1,471,962	0.000000	0.000000	0	90.00
90.01	09001 CLINIC - AMO	0	2,423,568	0.000000	0.000000	0	90.01
90.02	09002 CLINIC - AMH NEURO	0	566,532	0.000000	0.000000	0	90.02
90.03	09003 CLINIC - NIGLIAZZO	0	1,924,067	0.000000	0.000000	0	90.03
91.00	09100 EMERGENCY	0	3,054,559	0.000000	0.000000	286	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,227,857	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0.000000	0	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0.000000	0	97.00
200.00	Total (lines 50-199)	0	69,650,539			90,292	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151330	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/29/2014 6:49 pm
	Component CCN: 15M330	Title XIX	Subprovider - IPF 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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020 OP PSYCH	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0	0	90.00
90.01	09001 CLINIC - AMO	0	0	0	0	90.01
90.02	09002 CLINIC - AMH NEURO	0	0	0	0	90.02
90.03	09003 CLINIC - NIGLIAZZO	0	0	0	0	90.03
91.00	09100 EMERGENCY	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	0	0	0	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
200.00	Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151330 Component CCN: 15M330	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/29/2014 6:49 pm
	Title XIX	Subprovider - IPF	PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020 OP PSYCH	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
90.01	09001 CLINIC - AMO	0	0	90.01
90.02	09002 CLINIC - AMH NEURO	0	0	90.02
90.03	09003 CLINIC - NIGLIAZZO	0	0	90.03
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0	0	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
200.00	Total (Lines 50-199)	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151330	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/29/2014 6:49 pm
Cost Center Description		Cost		
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,352	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,308	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,542	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		44	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,155	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		152.53	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,801,778	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)		6,711	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)		6,711	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,795,067	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)		5,795,067	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)		1,091.76	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,352,743	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,352,743	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151330	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/29/2014 6:49 pm
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Cost Center Description	Title XVIII			Hospital	Cost	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	1,431,681	807	1,774.08	366	649,313	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						
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					2,184,593	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,186,649	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					766	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,091.76	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					836,288	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151330

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

worksheet D-1

Date/Time Prepared:
5/29/2014 6:49 pm

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

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151330 Component CCN: 15M330	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/29/2014 6:49 pm
	Title XVIII	Subprovider - IPF	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)	1,753	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,753	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)	1,753	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)	524	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,052,075	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)	2,052,075	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)	2,052,075	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)	1,170.61	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	613,400	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)	613,400	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151330 Component CCN: 15M330		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/29/2014 6:49 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					64,561	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					677,961	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)					2,173	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,173	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					675,788	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151330 Component CCN: 15M330		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/29/2014 6:49 pm	
		Title XVIII		Subprovider - IPF		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	2,052,075	0.000000	0	0	90.00
91.00	Nursing School cost	0	2,052,075	0.000000	0	0	91.00
92.00	Allied health cost	0	2,052,075	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,052,075	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151330	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
Cost Center Description		Title XIX	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,352	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,308	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,542	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		44	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)		295	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)		384	15.00
16.00	Nursery days (title V or XIX only)		47	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,801,778	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)		5,801,778	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)		5,801,778	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)		1,093.03	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		322,444	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)		322,444	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151330

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

Worksheet D-1

Date/Time Prepared:
5/29/2014 6:49 pm

Cost Center Description	Title XIX			Hospital	PPS	
	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)	369,501	384	962.24	47	45,225	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	1,431,681	807	1,774.08	30	53,222	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						
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					310,163	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					731,054	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)					42,084	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					14,017	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					56,101	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					674,953	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					766	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,093.03	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					837,261	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151330		Period: From 01/01/2013 To 12/31/2013		Worksheet D-I Date/Time Prepared: 5/29/2014 6:49 pm	
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	651,843	5,801,778	0.112352	837,261	94,068	90.00
91.00	Nursing School cost	0	5,801,778	0.000000	837,261	0	91.00
92.00	Allied health cost	0	5,801,778	0.000000	837,261	0	92.00
93.00	All other Medical Education	0	5,801,778	0.000000	837,261	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151330 Component CCN: 15M330	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/29/2014 6:49 pm
	Title XIX	Subprovider - IPF	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)	1,753	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,753	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)	1,753	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)	346	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)	384	15.00
16.00	Nursery days (title V or XIX only)	47	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,052,075	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)	2,052,075	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)	2,052,075	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)	1,170.61	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	405,031	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)	405,031	41.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151330 Component CCN: 15M330	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/29/2014 6:49 pm
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	Title XIX	Subprovider - IPF	PPS
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Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					28,847	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					433,878	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)					46,139	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					974	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					47,113	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					386,765	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151330 Component CCN: 15M330		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/29/2014 6:49 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	233,754	2,052,075	0.113911	0	0	90.00
91.00	Nursing School cost	0	2,052,075	0.000000	0	0	91.00
92.00	Allied health cost	0	2,052,075	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,052,075	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151330	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/29/2014 6:49 pm	
Cost Center Description		Title XVIII Ratio of Cost To Charges	Hospital Inpatient Program Charges	Cost Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		2,349,447	30.00
31.00	03100	INTENSIVE CARE UNIT		795,700	31.00
40.00	04000	SUBPROVIDER - IPF		10,243	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.624825	188,081	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.043910	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.188412	554,087	54.00
60.00	06000	LABORATORY	0.242614	1,210,077	60.00
65.00	06500	RESPIRATORY THERAPY	0.232301	1,384,791	65.00
66.00	06600	PHYSICAL THERAPY	0.547664	129,326	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.637674	57,778	67.00
68.00	06800	SPEECH PATHOLOGY	0.486567	42,851	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.496900	1,287,171	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.488395	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.370796	1,545,856	73.00
76.00	03020	OP PSYCH	0.588038	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.464127	0	90.00
90.01	09001	CLINIC - AMO	0.284798	0	90.01
90.02	09002	CLINIC - AMH NEURO	0.043729	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0.258666	0	90.03
91.00	09100	EMERGENCY	0.987419	6,173	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.681096	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES		0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		6,406,191	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		6,406,191	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151330 Component CCN: 15M330	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/29/2014 6:49 pm
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		673,639	40.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.624825	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.043910	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.188412	13,312	54.00
60.00	06000 LABORATORY	0.242614	63,700	60.00
65.00	06500 RESPIRATORY THERAPY	0.232301	15,200	65.00
66.00	06600 PHYSICAL THERAPY	0.547664	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.637674	539	67.00
68.00	06800 SPEECH PATHOLOGY	0.486567	547	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.496900	14,626	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.488395	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.370796	94,435	73.00
76.00	03020 OP PSYCH	0.588038	0	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.464127	0	90.00
90.01	09001 CLINIC - AMO	0.284798	0	90.01
90.02	09002 CLINIC - AMH NEURO	0.043729	0	90.02
90.03	09003 CLINIC - NIGLIAZZO	0.258666	0	90.03
91.00	09100 EMERGENCY	0.987419	175	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.681096	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES			95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	97.00
200.00	Total (sum of lines 50-94 and 96-98)		202,534	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)		202,534	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151330	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3
		Component CCN: 152330	Date/Time Prepared: 5/29/2014 6:49 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.624825	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.043910	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.188412	54.00
60.00	06000	LABORATORY	0.242614	60.00
65.00	06500	RESPIRATORY THERAPY	0.232301	65.00
66.00	06600	PHYSICAL THERAPY	0.547664	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.637674	67.00
68.00	06800	SPEECH PATHOLOGY	0.486567	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.496900	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.488395	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.370796	73.00
76.00	03020	OP PSYCH	0.588038	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.464127	90.00
90.01	09001	CLINIC - AMO	0.284798	90.01
90.02	09002	CLINIC - AMH NEURO	0.043729	90.02
90.03	09003	CLINIC - NIGLIAZZO	0.258666	90.03
91.00	09100	EMERGENCY	0.987419	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.681096	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	97.00
200.00	Total (sum of lines 50-94 and 96-98)			200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)			201.00
202.00	Net Charges (line 200 minus line 201)			202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151330	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/29/2014 6:49 pm	
Cost Center Description		Title XIX	Hospital	PPS	
		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		323,005	30.00
31.00	03100	INTENSIVE CARE UNIT		91,560	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY		30,745	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.624825	73,321	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.043910	35,650	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.188412	68,845	54.00
60.00	06000	LABORATORY	0.242614	170,907	60.00
65.00	06500	RESPIRATORY THERAPY	0.232301	112,507	65.00
66.00	06600	PHYSICAL THERAPY	0.547664	3,278	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.637674	2,336	67.00
68.00	06800	SPEECH PATHOLOGY	0.486567	924	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.496900	92,271	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.488395	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.370796	249,622	73.00
76.00	03020	OP PSYCH	0.588038	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.464127	0	90.00
90.01	09001	CLINIC - AMO	0.284798	0	90.01
90.02	09002	CLINIC - AMH NEURO	0.043729	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0.258666	0	90.03
91.00	09100	EMERGENCY	0.987419	4,478	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.681096	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		814,139	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)		814,139	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151330 Component CCN: 15M330	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/29/2014 6:49 pm	
Cost Center Description		Title XIX	Subprovider - IPF	PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		393,284	40.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.624825	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.043910	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.188412	750	54.00
60.00	06000	LABORATORY	0.242614	29,830	60.00
65.00	06500	RESPIRATORY THERAPY	0.232301	8,059	65.00
66.00	06600	PHYSICAL THERAPY	0.547664	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.637674	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.486567	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.496900	2,125	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.488395	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.370796	49,242	73.00
76.00	03020	OP PSYCH	0.588038	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.464127	0	90.00
90.01	09001	CLINIC - AMO	0.284798	0	90.01
90.02	09002	CLINIC - AMH NEURO	0.043729	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0.258666	0	90.03
91.00	09100	EMERGENCY	0.987419	286	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.681096	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES		0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		90,292	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)		90,292	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151330 Period: From 01/01/2013 To 12/31/2013
 Component CCN: 152330 Date/Time Prepared: 5/29/2014 6:49 pm

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.624825	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.043910	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.188412	0	0	54.00
60.00	06000 LABORATORY	0.242614	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.232301	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.547664	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.637674	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.486567	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.496900	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.488395	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.370796	0	0	73.00
76.00	03020 OP PSYCH	0.588038	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.464127	0	0	90.00
90.01	09001 CLINIC - AMO	0.284798	0	0	90.01
90.02	09002 CLINIC - AMH NEURO	0.043729	0	0	90.02
90.03	09003 CLINIC - NIGLIAZZO	0.258666	0	0	90.03
91.00	09100 EMERGENCY	0.987419	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.681096	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00	Total (sum of lines 50-94 and 96-98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151330	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/29/2014 6:49 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			3,666,990 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)			3,666,990 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			3,703,660 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			41,823 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,700,157 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)			1,961,680 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)			1,961,680 30.00
31.00	Primary payer payments			278 31.00
32.00	Subtotal (line 30 minus line 31)			1,961,402 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)			154,390 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			135,863 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			154,390 36.00
37.00	Subtotal (see instructions)			2,097,265 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)			2,097,265 40.00
40.01	Sequestration adjustment (see instructions)			31,669 40.01
41.00	Interim payments			2,048,794 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			16,802 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00
				Overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151330

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

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2014 6:49 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		3,818,067		1,784,694	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	08/12/2013	545,700	08/12/2013	264,100	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)		545,700		264,100	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)		4,363,767		2,048,794	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		348,643		16,802	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		4,712,410		2,065,596	7.00	
			0				
				Contractor Number	NPR Date (Mo/Day/Yr)		
				1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151330
Component CCN: 15M330

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

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2014 6:49 pm
PPS

Title XVIII

Subprovider -
IPF

		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		383,165		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)		383,165		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		229		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		383,394		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: 151330 Component CCN: 152330	Period: From 01/01/2013 To 12/31/2013	Worksheet E-1 Part I Date/Time Prepared: 5/29/2014 6:49 pm		
		Title XVIII		Swing Beds - SNF	Cost	
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		0		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 151330	Period:	Worksheet E-2
		Component CCN: 152330	From 01/01/2013 To 12/31/2013	Date/Time Prepared: 5/29/2014 6:49 pm
		Title XVIII	Swing Beds - SNF	Cost
			Part A	Part B
			1.00	2.00
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0	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)		0	0 3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00 4.00
5.00	Program days		0	0 5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0 6.00
7.00	Utilization review - physician compensation - SNF optional method only		0	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	0 8.00
9.00	Primary payer payments (see instructions)		0	0 9.00
10.00	Subtotal (line 8 minus line 9)		0	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)		0	0 12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		0	0 13.00
14.00	80% of Part B costs (line 12 x 80%)			0 14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0	0 15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0 16.00
17.00	Allowable bad debts (see instructions)		0	0 17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0 17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0 18.00
19.00	Total (see instructions)		0	0 19.00
19.01	Sequestration adjustment (see instructions)		0	0 19.01
20.00	Interim payments		0	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		0	0 22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	0 23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 151330	Period: From 01/01/2013	Worksheet E-2
		Component CCN: 15Z330	To 12/31/2013	Date/Time Prepared: 5/29/2014 6:49 pm
		Title XIX	Swing Beds - SNF	PPS
			Part A	Part B
			1.00	2.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 151330	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part V Date/Time Prepared: 5/29/2014 6:49 pm
Title XVIII	Hospital	Cost

		1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHS)			
1.00	Inpatient services	5,186,649	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	5,186,649	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,238,515	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 teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	5,238,515	19.00
20.00	Deductibles (exclude professional component)	481,824	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	4,756,691	22.00
23.00	Coinsurance	1,776	23.00
24.00	Subtotal (line 22 minus line 23)	4,754,915	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	33,799	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	29,743	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	33,799	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	4,784,658	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)	4,784,658	30.00
30.01	Sequestration adjustment (see instructions)	72,248	30.01
31.00	Interim payments	4,363,767	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	348,643	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151330	Period: From 01/01/2013	Worksheet E-3
		Component CCN: 15M330	To 12/31/2013	Part II
		Title XVIII	Subprovider - IPF	Date/Time Prepared: 5/29/2014 6:49 pm

			1.00	
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		469,479	1.00
2.00	Net IPF PPS outlier Payments		601	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTES in the new program growth period of a "new teaching program". (see inst.)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program". (see inst.)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		4.802740	9.00
10.00	Teaching Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9}))\}$ raised to the power of .5150 -1}.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		470,080	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		0	14.00
15.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)		0	15.00
16.00	Subtotal (see instructions)		470,080	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		470,080	18.00
19.00	Deductibles		46,176	19.00
20.00	Subtotal (line 18 minus line 19)		423,904	20.00
21.00	Coinsurance		34,632	21.00
22.00	Subtotal (line 20 minus line 21)		389,272	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	25.00
26.00	Subtotal (sum of lines 22 and 24)		389,272	26.00
27.00	Direct graduate medical education payments (from worksheet E-4, line 49)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.99	Recovery of Accelerated Depreciation		0	30.99
31.00	Total amount payable to the provider (see instructions)		389,272	31.00
31.01	Sequestration adjustment (see instructions)		5,878	31.01
32.00	Interim payments		383,165	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33		229	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from worksheet E-3, Part II, line 2		601	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151330	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2014 6:49 pm
		Title XIX	Hospital	PPS
			Inpatient 1.00	Outpatient 2.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0	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)		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)		0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		445,310	8.00
9.00	Ancillary service charges		814,139	9.00
10.00	Organ acquisition charges, net of revenue		0	10.00
11.00	Incentive from target amount computation		0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		1,259,449	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		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	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)		1,259,449	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		1,259,449	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		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	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	31.00
32.00	Deductibles		0	32.00
33.00	Coinsurance		0	33.00
34.00	Allowable bad debts (see instructions)		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	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		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	40.00
41.00	Interim payments		0	41.00
42.00	Balance due provider/program (line 40 minus 41)		0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151330 Component CCN: 15M330	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2014 6:49 pm
		Title XIX	Subprovider - IPF	PPS
			Inpatient 1.00	Outpatient 2.00

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0	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)		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)		0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		393,284	8.00
9.00	Ancillary service charges		90,292	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)		483,576	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		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	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)		483,576	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		483,576	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		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	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	31.00
32.00	Deductibles		0	32.00
33.00	Coinsurance		0	33.00
34.00	Allowable bad debts (see instructions)		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	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		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	40.00
41.00	Interim payments		0	41.00
42.00	Balance due provider/program (line 40 minus 41)		0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		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: 151330

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

Worksheet G

Date/Time Prepared:
5/29/2014 6:49 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	1,590,685	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	11,084,444	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	647,579	0	0	0	7.00
8.00	Prepaid expenses	159,098	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	1,089,016	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	14,570,822	0	0	0	11.00
FIXED ASSETS						
12.00	Land	360,100	0	0	0	12.00
13.00	Land improvements	1,530,852	0	0	0	13.00
14.00	Accumulated depreciation	-1,193,564	0	0	0	14.00
15.00	Buildings	37,653,083	0	0	0	15.00
16.00	Accumulated depreciation	-13,148,377	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	4,309,794	0	0	0	19.00
20.00	Accumulated depreciation	-1,869,252	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	20,925,295	0	0	0	23.00
24.00	Accumulated depreciation	-15,721,160	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)	32,846,771	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	5,594,020	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,594,020	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	53,011,613	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,765,366	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,596,167	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,343,291	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,704,824	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	34,231,186	0	0	0	46.00
47.00	Notes payable	1,183,483	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)	35,414,669	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	42,119,493	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	10,892,120				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)	10,892,120	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	53,011,613	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151330

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

Worksheet G-1

Date/Time Prepared:
5/29/2014 6:49 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		22,310,493			0	1.00
2.00	Net income (loss) (from wkst. G-3, line 29)		-606,418				2.00
3.00	Total (sum of line 1 and line 2)		21,704,075			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)		21,704,075			0	11.00
12.00	CHANGE IN PY FUND BALANCES	10,811,955		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)		10,811,955			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		10,892,120			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	CHANGE IN PY FUND BALANCES		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: 151330

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/29/2014 6:49 pm

Cost Center Description	Inpatient	Outpatient	Total	
	1.00	2.00	3.00	
PART I - PATIENT REVENUES				
General Inpatient Routine Services				
1.00 Hospital	5,517,233		5,517,233	1.00
2.00 SUBPROVIDER - IPF	2,405,589		2,405,589	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	0		0	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)	7,922,822		7,922,822	10.00
Intensive Care Type Inpatient Hospital Services				
11.00 INTENSIVE CARE UNIT	1,705,855		1,705,855	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)	1,705,855		1,705,855	16.00
17.00 Total inpatient routine care services (sum of lines 10 and 16)	9,628,677		9,628,677	17.00
18.00 Ancillary services	15,670,474	60,113,354	75,783,828	18.00
19.00 Outpatient services	0	1,821,367	1,821,367	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	0	0	0	22.00
23.00 AMBULANCE SERVICES	0	0	0	23.00
24.00 CMHC				24.00
25.00 AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00 HOSPICE	0	0	0	26.00
27.00 OTHER (SPECIFY)	0	0	0	27.00
28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	25,299,151	61,934,721	87,233,872	28.00
PART II - OPERATING EXPENSES				
29.00 Operating expenses (per wkst. A, column 3, line 200)		43,145,758		29.00
30.00 ADD (SPECIFY)	0			30.00
31.00	0			31.00
32.00	0			32.00
33.00	0			33.00
34.00	0			34.00
35.00	0			35.00
36.00 Total additions (sum of lines 30-35)		0		36.00
37.00 DEDUCT (SPECIFY)	0			37.00
38.00	0			38.00
39.00	0			39.00
40.00	0			40.00
41.00	0			41.00
42.00 Total deductions (sum of lines 37-41)		0		42.00
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		43,145,758		43.00

STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 151330	Period: From 01/01/2013 To 12/31/2013	Worksheet G-3 Date/Time Prepared: 5/29/2014 6:49 pm
				1.00
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)		87,233,872	1.00
2.00	Less contractual allowances and discounts on patients' accounts		47,105,574	2.00
3.00	Net patient revenues (line 1 minus line 2)		40,128,298	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)		43,145,758	4.00
5.00	Net income from service to patients (line 3 minus line 4)		-3,017,460	5.00
	OTHER INCOME			
6.00	Contributions, donations, bequests, etc		36,812	6.00
7.00	Income from investments		144,450	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		391,669	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		22,521	17.00
18.00	Revenue from sale of medical records and abstracts		24,125	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		190,258	22.00
23.00	Governmental appropriations		430,855	23.00
24.00	TRANSPORTATION		3,988	24.00
24.01			0	24.01
24.02	OB RENTALS		345	24.02
24.03	WORTHMAN FITNESS CENTER		91,161	24.03
24.04	CREDIT		1,157,512	24.04
24.05	GRANT		23,445	24.05
24.06	MISC		123,998	24.06
24.07			0	24.07
24.08			0	24.08
25.00	Total other income (sum of lines 6-24)		2,641,139	25.00
26.00	Total (line 5 plus line 25)		-376,321	26.00
27.00	INSTITUTIONAL PHARMACY CLEARING		155,463	27.00
27.01	LOSS ON ASSET DISPOSAL		74,634	27.01
28.00	Total other expenses (sum of line 27 and subscripts)		230,097	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)		-606,418	29.00