

Greene County General Hospital

Provider No's. 15-1317, 15-Z317 and Aim No. 100269150

**Hospital Statements of Reimbursable Costs
(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). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151317	Period: From 01/01/2013 To 12/31/2013	Worksheet 5 Parts I-III Date/Time Prepared: 6/2/2014 2:22 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 6/2/2014	Time: 2:22 pm
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GREENE COUNTY GENERAL HOSPITAL (151317) for the cost reporting period beginning 01/01/2013 and ending 12/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-899,253	62,162	194,193	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	-20,404	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	-919,657	62,162	194,193	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: 151317

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

Worksheet S-2
Part I
Date/Time Prepared:
6/2/2014 2:04 pm

		1.00	2.00	3.00	4.00					
Hospital and Hospital Health Care Complex Address:										
1.00	Street: R.R. 1	PO Box: 1000								1.00
2.00	City: LINTON	State: IN		Zip Code: 47441-9457		County: GREENE				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	GREENE COUNTY GENERAL HOSPITAL	151317	99915	1	02/01/2003	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	GREENE COUNTY GENERAL HOSPITAL	152317	99915		02/01/2003	N	O	N	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 OLTG									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.						0			23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151317	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 6/2/2014 2:04 pm		
		Urban/Rural S	Date of Geogr			
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.	1.00	1	2.00	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	
		Beginning:	Ending:			
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.	1.00		2.00	36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.		0		37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		Y/N	Y/N			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	1.00		2.00	39.00	
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.	N			58.00	
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00		
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		

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

Worksheet S-2
Part I
Date/Time Prepared:
6/2/2014 2:04 pm

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
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

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

Worksheet S-2
Part I
Date/Time Prepared:
6/2/2014 2:04 pm

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
		1.00	2.00	3.00	

66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00
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		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
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		1.00	2.00	3.00	
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Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00

71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	71.00
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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
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		1.00			
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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
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		V	XIX		
		1.00	2.00		

Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00

91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	91.00
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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
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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
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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
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95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	95.00
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151317	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 6/2/2014 2:04 pm		
		V 1.00	XIX 2.00			
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00		
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00		
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		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		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	76,247	0	0		118.01
			1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151317	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 6/2/2014 2:04 pm			
		1.00	2.00				
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y			140.00		
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:	Contractor's Number:		141.00		
142.00	Street:	PO Box:			142.00		
143.00	City:	State:	Zip Code:		143.00		
		1.00					
144.00	Are provider based physicians' costs included in worksheet A?	Y	144.00				
145.00	If costs for renal services are claimed on worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N	145.00				
		1.00	2.00				
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N	146.00				
147.00	was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00				
148.00	was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00				
149.00	was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00				
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00
							1.00
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y				167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	211,750				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)	01/01/2013	12/31/2013		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
Description		Y/N	Date	Y/N
0		1.00	2.00	3.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/10/2014	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
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

	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	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	WADE	HILL		41.00
42.00	Enter the employer/company name of the cost report preparer.	BRADLEY ASSOCIATES, INC.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3172375500	WADEH@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)	04/10/2014		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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

VOLUNTARY CONTACT INFORMATION

Provider CCN: 151317

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

Worksheet S-2
Part V
Date/Time Prepared:
6/2/2014 2:04 pm

		1.00	
Cost Report Preparer Contact Information			
1.00	First Name	WADE	1.00
2.00	Last Name	HILL	2.00
3.00	Title	PARTNER	3.00
4.00	Employer	BRADELY ASSOCIATES	4.00
5.00	Phone Number	(317)237-5500	5.00
6.00	E-mail Address	WADEH@BRADLEYCPA.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	APRIL	13.00
14.00	Last Name	SETTLES	14.00
15.00	Title	CFO	15.00
16.00	Employer	GREENE COUNTY GENERAL HOSPITAL	16.00
17.00	Phone Number	(812)847-2281	17.00
18.00	E-mail Address	APRIL.SETTLES@MYGCGH.ORG	18.00
19.00	Department		19.00
20.00	Mailing Address 1	1185 N 1000 W	20.00
21.00	Mailing Address 2		21.00
22.00	City	LINTON	22.00
23.00	State	IN	23.00
24.00	Zip	47441	24.00

Provider CCN: 151317

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

Worksheet S-2
Part IX
Date/Time Prepared:
6/2/2014 2:04 pm

		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.	N	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.	N	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.	N	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.	N	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.	N	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151317

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

Worksheet S-3
Part I
Date/Time Prepared:
6/2/2014 2:04 pm

Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	I/P Days / O/P	
	Line Number		Available		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	20	7,300	68,904.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		20	7,300	68,904.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	5	1,825	11,088.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT	33.00	0	0	0.00	0	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	79,992.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151317

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

Worksheet S-3
Part I
Date/Time Prepared:
6/2/2014 2:04 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,990	46	2,871			1.00
2.00 HMO and other (see instructions)	0	152				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	154	0	154			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	29			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	2,144	46	3,054			7.00
8.00 INTENSIVE CARE UNIT	374	13	462			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT	0	0	0			10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		0	140			13.00
14.00 Total (see instructions)	2,518	59	3,656	0.00	226.70	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	226.70	27.00
28.00 Observation Bed Days		0	866			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	14	33			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151317

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

Worksheet S-3
Part I
Date/Time Prepared:
6/2/2014 2:04 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	665	71	1,032	1.00
2.00 HMO and other (see instructions)				0			2.00
3.00 HMO IPF Subprovider							3.00
4.00 HMO IRF Subprovider							4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0	665		71	1,032	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

				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)			0.430355	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			1,126,368	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			2,061,251	5.00
6.00	Medicaid charges			7,759,385	6.00
7.00	Medicaid cost (line 1 times line 6)			3,339,290	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)			151,671	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP			0	9.00
10.00	Stand-alone SCHIP charges			0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			151,671	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	1,118,740	949,688	2,068,428	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	481,455	408,703	890,158	21.00
22.00	Partial payment by patients approved for charity care	44,645	19,423	64,068	22.00
23.00	Cost of charity care (line 21 minus line 22)	436,810	389,280	826,090	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)			15,963,263	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			747,340	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			15,215,923	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			6,548,249	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			7,374,339	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			7,526,010	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151317

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

Worksheet A

Date/Time Prepared:
6/2/2014 2:04 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	NEW CAP REL COSTS-BLDG & FIXT		499,068	499,068	38,343	537,411	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		273,386	273,386	814	274,200	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		3,885,702	3,885,702	134,272	4,019,974	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,716,705	3,726,988	5,443,693	-216,966	5,226,727	5.00
7.00	00700	OPERATION OF PLANT	381,776	1,068,138	1,449,914	0	1,449,914	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	165,833	165,833	0	165,833	8.00
9.00	00900	HOUSEKEEPING	349,975	67,383	417,358	0	417,358	9.00
10.00	01000	DIETARY	505,657	579,836	1,085,493	-960,506	124,987	10.00
11.00	01100	CAFETERIA	0	0	0	915,793	915,793	11.00
13.00	01300	NURSING ADMINISTRATION	553,903	113,453	667,356	0	667,356	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	327,918	327,918	0	327,918	14.00
15.00	01500	PHARMACY	698,568	89,841	788,409	0	788,409	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	228,742	27,909	256,651	0	256,651	16.00
17.00	01700	SOCIAL SERVICE	146,873	0	146,873	0	146,873	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	246,796	246,796	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,580,418	655,840	3,236,258	63,391	3,299,649	30.00
31.00	03100	INTENSIVE CARE UNIT	738,208	31,252	769,460	0	769,460	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
43.00	04300	NURSERY	31,035	147	31,182	0	31,182	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	392,089	206,412	598,501	0	598,501	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,289	1,289	24,859	26,148	52.00
53.00	05300	ANESTHESIOLOGY	407,986	7,396	415,382	-246,796	168,586	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	930,090	793,080	1,723,170	0	1,723,170	54.00
60.00	06000	LABORATORY	810,338	1,619,117	2,429,455	0	2,429,455	60.00
65.00	06500	RESPIRATORY THERAPY	449,688	69,851	519,539	0	519,539	65.00
66.00	06600	PHYSICAL THERAPY	392,422	20,453	412,875	-93,388	319,487	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	93,388	93,388	67.00
68.00	06800	SPEECH PATHOLOGY	11,382	0	11,382	0	11,382	68.00
69.00	06900	ELECTROCARDIOLOGY	27,241	23,407	50,648	0	50,648	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	267,952	267,952	-2,860	265,092	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,860	2,860	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,367,293	1,367,293	0	1,367,293	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	725,276	1,378,715	2,103,991	0	2,103,991	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,078,372	17,267,659	29,346,031	0	29,346,031	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FOUNDATION/ MOBS	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	12,078,372	17,267,659	29,346,031	0	29,346,031	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151317

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

Worksheet A

Date/Time Prepared:
6/2/2014 2:04 pm

Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	0	537,411	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	-119,535	154,665	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	477,396	4,497,370	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-1,448,656	3,778,071	5.00
7.00	00700 OPERATION OF PLANT	0	1,449,914	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	165,833	8.00
9.00	00900 HOUSEKEEPING	0	417,358	9.00
10.00	01000 DIETARY	0	124,987	10.00
11.00	01100 CAFETERIA	-307,832	607,961	11.00
13.00	01300 NURSING ADMINISTRATION	0	667,356	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-59	327,859	14.00
15.00	01500 PHARMACY	0	788,409	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-5,845	250,806	16.00
17.00	01700 SOCIAL SERVICE	0	146,873	17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	246,796	19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-686,253	2,613,396	30.00
31.00	03100 INTENSIVE CARE UNIT	0	769,460	31.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	33.00
43.00	04300 NURSERY	0	31,182	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	598,501	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	26,148	52.00
53.00	05300 ANESTHESIOLOGY	0	168,586	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	1,723,170	54.00
60.00	06000 LABORATORY	-40,000	2,389,455	60.00
65.00	06500 RESPIRATORY THERAPY	0	519,539	65.00
66.00	06600 PHYSICAL THERAPY	0	319,487	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	93,388	67.00
68.00	06800 SPEECH PATHOLOGY	0	11,382	68.00
69.00	06900 ELECTROCARDIOLOGY	0	50,648	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	265,092	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	2,860	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,367,293	73.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	-981,114	1,122,877	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	-3,111,898	26,234,133	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950 FOUNDATION/ MOBS	1,271,973	1,271,973	194.00
200.00	TOTAL (SUM OF LINES 118-199)	-1,839,925	27,506,106	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 151317

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

Worksheet Non-CMS w

Date/Time Prepared:
6/2/2014 2:04 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
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
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
17.00	SOCIAL SERVICE	01700		17.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
33.00	BURN INTENSIVE CARE UNIT	03300		33.00
43.00	NURSERY	04300		43.00
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
OUTPATIENT SERVICE COST CENTERS				
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
194.00	FOUNDATION/ MOBS	07950		194.00
200.00	TOTAL (SUM OF LINES 118-199)			200.00

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	38,343	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	814	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	134,272	3.00
	TOTALS		0	173,429	
B - LABOR & DELIVERY					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	24,859	0	1.00
	TOTALS		24,859	0	
C - DIETARY/ CAFETERIA					
1.00	ADMINISTRATIVE & GENERAL	5.00	20,829	23,884	1.00
2.00	CAFETERIA	11.00	426,605	489,188	2.00
	TOTALS		447,434	513,072	
D - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	2,860	1.00
	TOTALS		0	2,860	
E - THERAPY					
1.00	OCCUPATIONAL THERAPY	67.00	93,388	0	1.00
	TOTALS		93,388	0	
F - OB RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	0	88,250	1.00
	TOTALS		0	88,250	
G - CRNA SALARY					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	246,796	0	1.00
	TOTALS		246,796	0	
500.00	Grand Total: Increases		812,477	777,611	500.00

Provider CCN: 151317

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

Worksheet A-6

Date/Time Prepared:
6/2/2014 2:04 pm

		Decreases						
Cost Center		Line #	Salary	Other	Wkst. A-7	Ref.		
6.00		7.00	8.00	9.00	10.00			
A - INSURANCE								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	173,429		12		1.00
2.00		0.00	0	0		12		2.00
3.00		0.00	0	0		0		3.00
TOTALS			0	173,429				
B - LABOR & DELIVERY								
1.00	ADULTS & PEDIATRICS	30.00	24,859	0		0		1.00
TOTALS			24,859	0				
C - DIETARY/ CAFETERIA								
1.00	DIETARY	10.00	447,434	513,072		0		1.00
2.00		0.00	0	0		0		2.00
TOTALS			447,434	513,072				
D - IMPLANTABLE DEVICES								
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,860		0		1.00
TOTALS			0	2,860				
E - THERAPY								
1.00	PHYSICAL THERAPY	66.00	93,388	0		0		1.00
TOTALS			93,388	0				
F - OB RECLASS								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	88,250		0		1.00
TOTALS			0	88,250				
G - CRNA SALARY								
1.00	ANESTHESIOLOGY	53.00	246,796	0		0		1.00
TOTALS			246,796	0				
500.00	Grand Total: Decreases		812,477	777,611				500.00

Provider CCN: 151317

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

Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
6/2/2014 2:04 pm

Increases			Decreases			
Cost Center	Line #	Salary	Cost Center	Line #	Salary	
	2.00	4.00	6.00	7.00	8.00	
A - INSURANCE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	ADMINISTRATIVE & GENERAL	5.00	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00		0.00	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		0.00	0	3.00
	TOTALS		TOTALS		0	
B - LABOR & DELIVERY						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	ADULTS & PEDIATRICS	30.00	24,859	1.00
	TOTALS	24,859	TOTALS		24,859	
C - DIETARY/ CAFETERIA						
1.00	ADMINISTRATIVE & GENERAL	5.00	DIETARY	10.00	447,434	1.00
2.00	CAFETERIA	11.00		0.00	0	2.00
	TOTALS	447,434	TOTALS		447,434	
D - IMPLANTABLE DEVICES						
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1.00
	TOTALS	0	TOTALS		0	
E - THERAPY						
1.00	OCCUPATIONAL THERAPY	67.00	PHYSICAL THERAPY	66.00	93,388	1.00
	TOTALS	93,388	TOTALS		93,388	
F - OB RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	ADMINISTRATIVE & GENERAL	5.00	0	1.00
	TOTALS	0	TOTALS		0	
G - CRNA SALARY						
1.00	NONPHYSICIAN ANESTHETISTS	19.00	ANESTHESIOLOGY	53.00	246,796	1.00
	TOTALS	246,796	TOTALS		246,796	
500.00	Grand Total: Increases		Grand Total: Decreases		812,477	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151317

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

Worksheet A-7
Part I
Date/Time Prepared:
6/2/2014 2:04 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00 Land	759,198	0	0	0	0	1.00
2.00 Land Improvements	425,781	264,115	0	264,115	0	2.00
3.00 Buildings and Fixtures	7,173,272	3,515,888	0	3,515,888	0	3.00
4.00 Building Improvements	0	0	0	0	0	4.00
5.00 Fixed Equipment	935,079	2,566,488	0	2,566,488	0	5.00
6.00 Movable Equipment	3,608,550	1,045,469	0	1,045,469	0	6.00
7.00 HIT designated Assets	209,341	530,011	0	530,011	0	7.00
8.00 Subtotal (sum of lines 1-7)	13,111,221	7,921,971	0	7,921,971	0	8.00
9.00 Reconciling Items	0	0	0	0	0	9.00
10.00 Total (line 8 minus line 9)	13,111,221	7,921,971	0	7,921,971	0	10.00
	Ending Balance	Fully Depreciated Assets				
	6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00 Land	759,198	0				1.00
2.00 Land Improvements	689,896	0				2.00
3.00 Buildings and Fixtures	10,689,160	0				3.00
4.00 Building Improvements	0	0				4.00
5.00 Fixed Equipment	3,501,567	0				5.00
6.00 Movable Equipment	4,654,019	0				6.00
7.00 HIT designated Assets	739,352	0				7.00
8.00 Subtotal (sum of lines 1-7)	21,033,192	0				8.00
9.00 Reconciling Items	0	0				9.00
10.00 Total (line 8 minus line 9)	21,033,192	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151317

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

Worksheet A-7
Part II
Date/Time Prepared:
6/2/2014 2:04 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	499,068	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	273,386	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	772,454	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	499,068				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	273,386				2.00
3.00	Total (sum of lines 1-2)	0	772,454				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151317

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

Worksheet A-7
Part III
Date/Time Prepared:
6/2/2014 2:04 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	10,689,160	0	10,689,160	0.696672	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4,654,019	0	4,654,019	0.303328	0	2.00
3.00	Total (sum of lines 1-2)	15,343,179	0	15,343,179	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	499,068	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	153,851	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	652,919	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	38,343	0	0	537,411	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	814	0	0	154,665	2.00
3.00	Total (sum of lines 1-2)	0	39,157	0	0	692,076	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)			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	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
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)	B	-102,253	ADULTS & PEDIATRICS	30.00	9	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-3,519	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-1,605,114			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	B	-181	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	1,797,865			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-307,832	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employee and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-5,845	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0 NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0 NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0 ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151317

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

Worksheet A-8

Date/Time Prepared:
6/2/2014 2:04 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7	Ref.
	1.00	2.00	3.00	4.00	5.00	
33.00 FLU SHOT	B	-59	CENTRAL SERVICES & SUPPLY	14.00		0 33.00
33.01 CPR TRAINING	B	-1,002	ADMINISTRATIVE & GENERAL	5.00		0 33.01
33.02 MISC INCOME	B	-5,045	ADMINISTRATIVE & GENERAL	5.00		0 33.02
33.03 ADVERTISING	A	-2,223	ADMINISTRATIVE & GENERAL	5.00		0 33.03
33.04 AHA DUES	A	-2,054	ADMINISTRATIVE & GENERAL	5.00		0 33.04
33.05 IHA DUES	A	-639	ADMINISTRATIVE & GENERAL	5.00		0 33.05
33.06 MARKETING & ADVERTISING	A	-143,695	ADMINISTRATIVE & GENERAL	5.00		0 33.06
33.07 RENTAL OF PROVIDER SPACE - BENEFITS	B	-48,496	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 33.07
33.09 HIT ADDITIONS DEPR EXPENSE	A	-119,353	NEW CAP REL COSTS-MVBLE EQUIP	2.00		9 33.09
33.10 LOSS ON DISPOSAL DEPR	A	-1	NEW CAP REL COSTS-MVBLE EQUIP	2.00		9 33.10
33.12 HOSPITAL ASSESSMENT FEE	A	-1,285,659	ADMINISTRATIVE & GENERAL	5.00		0 33.12
33.14 SPONSOR FEE	A	-4,820	ADMINISTRATIVE & GENERAL	5.00		0 33.14
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-1,839,925				50.00

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

Provider CCN: 151317

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

worksheet A-8-1

Date/Time Prepared:
6/2/2014 2:04 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	194.00	FOUNDATION/ MOBS	1,271,973	0
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	525,892	0
3.00	0.00		0	0
4.00	0.00		0	0
5.00	0		1,797,865	0

* 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	C	GCGH FOUNDATION	0.00	0.00	6.00
7.00	C	GCH-WORTHINGTON	0.00	0.00	7.00
8.00	C	GCH-BLOOMFIELD	0.00	0.00	8.00
9.00	C	GCGH, LLC	0.00	0.00	9.00
10.00	C	GC HOME HEALTH	0.00	0.00	10.00
10.01	C	GCH-LINTON	0.00	0.00	10.01
10.02	C	LINTON MD CLIN	0.00	0.00	10.02
10.03	C	LONE TREE CLIN	0.00	0.00	10.03
10.04	C	WESTGATE CLIN	0.00	0.00	10.04
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: 151317

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

Worksheet A-8-1

Date/Time Prepared:
6/2/2014 2:04 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	1,271,973	0	1.00
2.00	525,892	0	2.00
3.00	0	0	3.00
4.00	0	0	4.00
5.00	1,797,865		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		6.00
7.00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
10.01		10.01
10.02		10.02
10.03		10.03
10.04		10.04
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: 151317

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

Worksheet A-8-2

Date/Time Prepared:
6/2/2014 2:04 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	91.00	EMERGENCY	1,322,360	981,114	341,246	0	0	1.00
2.00	60.00	LABORATORY	40,000	40,000	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	584,000	584,000	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,946,360	1,605,114	341,246	0	0	200.00

	wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	91.00	EMERGENCY	0	0	0	981,114	1.00
2.00	60.00	LABORATORY	0	0	0	40,000	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	584,000	3.00
4.00	0.00		0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	1,605,114	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151317

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

Worksheet B
Part I
Date/Time Prepared:
6/2/2014 2:04 pm

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	537,411	537,411			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	154,665		154,665		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	4,497,370	0	0	4,497,370	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,778,071	82,322	23,692	519,654	5.00
7.00 00700	OPERATION OF PLANT	1,449,914	50,905	14,650	114,180	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	165,833	6,770	1,948	0	8.00
9.00 00900	HOUSEKEEPING	417,358	4,985	1,435	104,669	9.00
10.00 01000	DIETARY	124,987	30,730	8,844	17,413	10.00
11.00 01100	CAFETERIA	607,961	18,750	5,396	127,587	11.00
13.00 01300	NURSING ADMINISTRATION	667,356	4,698	1,352	165,659	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	327,859	7,098	2,043	0	14.00
15.00 01500	PHARMACY	788,409	17,006	4,894	208,925	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	250,806	10,349	2,978	68,411	16.00
17.00 01700	SOCIAL SERVICE	146,873	2,544	732	43,926	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	246,796	0	0	73,811	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	2,613,396	92,997	26,764	764,306	30.00
31.00 03100	INTENSIVE CARE UNIT	769,460	26,863	7,731	220,780	31.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
43.00 04300	NURSERY	31,182	5,221	1,503	9,282	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	598,501	44,474	12,799	117,264	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	26,148	21,365	6,149	7,435	52.00
53.00 05300	ANESTHESIOLOGY	168,586	0	0	48,208	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,723,170	26,186	7,536	278,168	54.00
60.00 06000	LABORATORY	2,389,455	19,816	5,703	242,353	60.00
65.00 06500	RESPIRATORY THERAPY	519,539	4,544	1,308	134,491	65.00
66.00 06600	PHYSICAL THERAPY	319,487	6,698	1,928	89,434	66.00
67.00 06700	OCCUPATIONAL THERAPY	93,388	6,698	1,928	27,930	67.00
68.00 06800	SPEECH PATHOLOGY	11,382	2,062	593	3,404	68.00
69.00 06900	ELECTROCARDIOLOGY	50,648	4,031	1,160	8,147	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	265,092	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	2,860	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,367,293	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	1,122,877	26,955	7,758	216,913	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	26,234,133	524,067	150,824	3,612,350	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,918	1,128	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	9,426	2,713	0	192.00
194.00 07950	FOUNDATION/ MOBS	1,271,973	0	0	885,020	194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	TOTAL (sum lines 118-201)	27,506,106	537,411	154,665	4,497,370	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151317

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

Worksheet B
Part 1
Date/Time Prepared:
6/2/2014 2:04 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	4,403,739					5.00
7.00	00700 OPERATION OF PLANT	310,642	1,940,291				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	33,273	32,497	240,321			8.00
9.00	00900 HOUSEKEEPING	100,732	23,930	24,872	677,981		9.00
10.00	01000 DIETARY	34,688	147,518	6,271	4,337	374,788	10.00
11.00	01100 CAFETERIA	144,812	90,008	0	2,024	329,780	11.00
13.00	01300 NURSING ADMINISTRATION	159,942	22,551	0	15,034	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	64,239	34,073	0	5,782	0	14.00
15.00	01500 PHARMACY	194,285	81,637	0	6,939	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	63,389	49,682	0	4,626	0	16.00
17.00	01700 SOCIAL SERVICE	36,994	12,211	0	2,313	0	17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	61,114	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	666,671	446,444	73,155	271,770	37,863	30.00
31.00	03100 INTENSIVE CARE UNIT	195,353	128,956	23,440	44,813	7,145	31.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
43.00	04300 NURSERY	8,995	25,062	0	4,048	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	147,356	213,498	18,974	70,834	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	11,646	102,564	0	1,735	0	52.00
53.00	05300 ANESTHESIOLOGY	41,325	0	0	578	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	387,921	125,706	21,494	33,249	0	54.00
60.00	06000 LABORATORY	506,537	95,129	0	31,803	0	60.00
65.00	06500 RESPIRATORY THERAPY	125,786	21,813	0	8,674	0	65.00
66.00	06600 PHYSICAL THERAPY	79,592	32,153	22,462	12,432	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	24,770	32,153	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	3,325	9,897	0	289	0	68.00
69.00	06900 ELECTROCARDIOLOGY	12,197	19,351	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	50,532	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	545	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	260,632	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	262,006	129,399	36,305	108,708	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,989,299	1,876,232	226,973	629,988	374,788	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	962	18,809	0	7,228	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	2,314	45,250	13,348	37,296	0	192.00
194.00	07950 FOUNDATION/ MOBS	411,164	0	0	3,469	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	4,403,739	1,940,291	240,321	677,981	374,788	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151317

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DIETARY						10.00
11.00	01100 CAFETERIA	1,326,318					11.00
13.00	01300 NURSING ADMINISTRATION	70,376	1,106,968				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	441,094			14.00
15.00	01500 PHARMACY	80,301	0	0	1,382,396		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	450,241	16.00
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	416,842	653,988	0	0	92,338	30.00
31.00	03100 INTENSIVE CARE UNIT	109,173	171,283	0	0	14,499	31.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
43.00	04300 NURSERY	9,023	14,156	0	0	4,579	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	55,940	87,765	0	0	18,315	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3,609	0	0	0	1,526	52.00
53.00	05300 ANESTHESIOLOGY	9,023	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	149,775	0	0	0	81,654	54.00
60.00	06000 LABORATORY	157,895	0	0	0	19,078	60.00
65.00	06500 RESPIRATORY THERAPY	69,474	0	0	0	763	65.00
66.00	06600 PHYSICAL THERAPY	61,353	0	0	0	3,052	66.00
67.00	06700 OCCUPATIONAL THERAPY	902	0	0	0	763	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	18,045	0	0	0	2,289	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	436,386	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	4,708	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	1,382,396	3,052	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	114,587	179,776	0	0	62,576	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,326,318	1,106,968	441,094	1,382,396	304,484	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	145,757	192.00
194.00	07950 FOUNDATION/ MOBS	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,326,318	1,106,968	441,094	1,382,396	450,241	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151317

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

Worksheet B
Part I
Date/Time Prepared:
6/2/2014 2:04 pm

Cost Center Description		SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500						15.00
16.00	01600						16.00
17.00	01700	245,593					17.00
19.00	01900	0	381,721				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	192,533	0	6,349,067	0	6,349,067	30.00
31.00	03100	34,868	0	1,754,364	0	1,754,364	31.00
33.00	03300	0	0	0	0	0	33.00
43.00	04300	0	0	113,051	0	113,051	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	9,096	0	1,394,816	0	1,394,816	50.00
52.00	05200	6,064	0	188,241	0	188,241	52.00
53.00	05300	0	381,721	649,441	0	649,441	53.00
54.00	05400	0	0	2,834,859	0	2,834,859	54.00
60.00	06000	0	0	3,467,769	0	3,467,769	60.00
65.00	06500	0	0	886,392	0	886,392	65.00
66.00	06600	0	0	628,591	0	628,591	66.00
67.00	06700	0	0	188,532	0	188,532	67.00
68.00	06800	0	0	30,952	0	30,952	68.00
69.00	06900	0	0	115,868	0	115,868	69.00
71.00	07100	0	0	752,010	0	752,010	71.00
72.00	07200	0	0	8,113	0	8,113	72.00
73.00	07300	0	0	3,013,373	0	3,013,373	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	3,032	0	2,270,892	0	2,270,892	91.00
92.00	09200				0		92.00
SPECIAL PURPOSE COST CENTERS							
118.00		245,593	381,721	24,646,331	0	24,646,331	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	32,045	0	32,045	190.00
192.00	19200	0	0	256,104	0	256,104	192.00
194.00	07950	0	0	2,571,626	0	2,571,626	194.00
200.00				0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		245,593	381,721	27,506,106	0	27,506,106	202.00

COST ALLOCATION STATISTICS

Provider CCN: 151317

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

Worksheet Non-CMS W

Date/Time Prepared:
6/2/2014 2:04 pm

Cost Center Description		Statistics Code	Statistics Description		
		1.00	2.00		
GENERAL SERVICE COST CENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE	FEET	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	3	SQUARE	FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES		4.00
5.00	ADMINISTRATIVE & GENERAL	-18	ACCUM.	COST	5.00
7.00	OPERATION OF PLANT	3	SQUARE	FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	8	POUNDS OF	LAUNDRY	8.00
9.00	HOUSEKEEPING	9	HOURS OF	SERVICE	9.00
10.00	DIETARY	10	MEALS	SERVED	10.00
11.00	CAFETERIA	11	HOURS		11.00
13.00	NURSING ADMINISTRATION	13	DIRECT	NRSING 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
17.00	SOCIAL SERVICE	17	TIME	SPENT	17.00
19.00	NONPHYSICIAN ANESTHETISTS	19	ASSIGNED	TIME	19.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151317

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

Worksheet B
Part II
Date/Time Prepared:
6/2/2014 2:04 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT
		NEW BLDG & FIXT	NEW MVBLE EQUIP		
		0	1.00		
GENERAL SERVICE COST CENTERS					
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	82,322	23,692	106,014 0 5.00
7.00 00700	OPERATION OF PLANT	0	50,905	14,650	65,555 0 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	6,770	1,948	8,718 0 8.00
9.00 00900	HOUSEKEEPING	0	4,985	1,435	6,420 0 9.00
10.00 01000	DIETARY	0	30,730	8,844	39,574 0 10.00
11.00 01100	CAFETERIA	0	18,750	5,396	24,146 0 11.00
13.00 01300	NURSING ADMINISTRATION	0	4,698	1,352	6,050 0 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	7,098	2,043	9,141 0 14.00
15.00 01500	PHARMACY	0	17,006	4,894	21,900 0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	10,349	2,978	13,327 0 16.00
17.00 01700	SOCIAL SERVICE	0	2,544	732	3,276 0 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	0	92,997	26,764	119,761 0 30.00
31.00 03100	INTENSIVE CARE UNIT	0	26,863	7,731	34,594 0 31.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0 33.00
43.00 04300	NURSERY	0	5,221	1,503	6,724 0 43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	44,474	12,799	57,273 0 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	21,365	6,149	27,514 0 52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	184,126	26,186	7,536	217,848 0 54.00
60.00 06000	LABORATORY	0	19,816	5,703	25,519 0 60.00
65.00 06500	RESPIRATORY THERAPY	0	4,544	1,308	5,852 0 65.00
66.00 06600	PHYSICAL THERAPY	0	6,698	1,928	8,626 0 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	6,698	1,928	8,626 0 67.00
68.00 06800	SPEECH PATHOLOGY	0	2,062	593	2,655 0 68.00
69.00 06900	ELECTROCARDIOLOGY	0	4,031	1,160	5,191 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
OUTPATIENT SERVICE COST CENTERS					
91.00 09100	EMERGENCY	0	26,955	7,758	34,713 0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0 92.00
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1-117)	184,126	524,067	150,824	859,017 0 118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,918	1,128	5,046 0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	9,426	2,713	12,139 0 192.00
194.00 07950	FOUNDATION/ MOBS	0	0	0	0 194.00
200.00	Cross Foot Adjustments				0 200.00
201.00	Negative Cost Centers		0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	184,126	537,411	154,665	876,202 0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151317

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	106,014					5.00
7.00	00700	7,478	73,033				7.00
8.00	00800	801	1,223	10,742			8.00
9.00	00900	2,425	901	1,112	10,858		9.00
10.00	01000	835	5,553	280	69	46,311	10.00
11.00	01100	3,486	3,388	0	32	40,749	11.00
13.00	01300	3,850	849	0	241	0	13.00
14.00	01400	1,546	1,283	0	93	0	14.00
15.00	01500	4,677	3,073	0	111	0	15.00
16.00	01600	1,526	1,870	0	74	0	16.00
17.00	01700	891	460	0	37	0	17.00
19.00	01900	1,471	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	16,049	16,802	3,269	4,353	4,679	30.00
31.00	03100	4,703	4,854	1,048	718	883	31.00
33.00	03300	0	0	0	0	0	33.00
43.00	04300	217	943	0	65	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,547	8,036	848	1,134	0	50.00
52.00	05200	280	3,861	0	28	0	52.00
53.00	05300	995	0	0	9	0	53.00
54.00	05400	9,339	4,732	961	532	0	54.00
60.00	06000	12,194	3,581	0	509	0	60.00
65.00	06500	3,028	821	0	139	0	65.00
66.00	06600	1,916	1,210	1,004	199	0	66.00
67.00	06700	596	1,210	0	0	0	67.00
68.00	06800	80	373	0	5	0	68.00
69.00	06900	294	728	0	0	0	69.00
71.00	07100	1,217	0	0	0	0	71.00
72.00	07200	13	0	0	0	0	72.00
73.00	07300	6,275	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	6,308	4,871	1,623	1,741	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		96,037	70,622	10,145	10,089	46,311	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	23	708	0	116	0	190.00
192.00	19200	56	1,703	597	597	0	192.00
194.00	07950	9,898	0	0	56	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		106,014	73,033	10,742	10,858	46,311	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151317

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

Worksheet B
Part II
Date/Time Prepared:
6/2/2014 2:04 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	71,801					11.00
13.00	01300	3,810	14,800				13.00
14.00	01400	0	0	12,063			14.00
15.00	01500	4,347	0	0	34,108		15.00
16.00	01600	0	0	0	0	16,797	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	22,568	8,744	0	0	3,445	30.00
31.00	03100	5,910	2,290	0	0	541	31.00
33.00	03300	0	0	0	0	0	33.00
43.00	04300	488	189	0	0	171	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,028	1,173	0	0	683	50.00
52.00	05200	195	0	0	0	57	52.00
53.00	05300	488	0	0	0	0	53.00
54.00	05400	8,108	0	0	0	3,046	54.00
60.00	06000	8,548	0	0	0	712	60.00
65.00	06500	3,761	0	0	0	28	65.00
66.00	06600	3,321	0	0	0	114	66.00
67.00	06700	49	0	0	0	28	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	977	0	0	0	85	69.00
71.00	07100	0	0	11,934	0	0	71.00
72.00	07200	0	0	129	0	0	72.00
73.00	07300	0	0	0	34,108	114	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	6,203	2,404	0	0	2,334	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		71,801	14,800	12,063	34,108	11,358	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	5,439	192.00
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		71,801	14,800	12,063	34,108	16,797	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151317

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

Worksheet B
Part II
Date/Time Prepared:
6/2/2014 2:04 pm

Cost Center Description		SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500						15.00
16.00	01600						16.00
17.00	01700	4,664					17.00
19.00	01900	0	1,471				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	3,656		203,326	0	203,326	30.00
31.00	03100	662		56,203	0	56,203	31.00
33.00	03300	0		0	0	0	33.00
43.00	04300	0		8,797	0	8,797	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	173		75,895	0	75,895	50.00
52.00	05200	115		32,050	0	32,050	52.00
53.00	05300	0		1,492	0	1,492	53.00
54.00	05400	0		244,566	0	244,566	54.00
60.00	06000	0		51,063	0	51,063	60.00
65.00	06500	0		13,629	0	13,629	65.00
66.00	06600	0		16,390	0	16,390	66.00
67.00	06700	0		10,509	0	10,509	67.00
68.00	06800	0		3,113	0	3,113	68.00
69.00	06900	0		7,275	0	7,275	69.00
71.00	07100	0		13,151	0	13,151	71.00
72.00	07200	0		142	0	142	72.00
73.00	07300	0		40,497	0	40,497	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	58		60,255	0	60,255	91.00
92.00	09200				0		92.00
SPECIAL PURPOSE COST CENTERS							
118.00		4,664	0	838,353	0	838,353	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0		5,893	0	5,893	190.00
192.00	19200	0		20,531	0	20,531	192.00
194.00	07950	0		9,954	0	9,954	194.00
200.00			1,471	1,471	0	1,471	200.00
201.00		0	0	0	0	0	201.00
202.00		4,664	1,471	876,202	0	876,202	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151317

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

Worksheet B-1

Date/Time Prepared:
6/2/2014 2:04 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	52,395				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		52,395			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	15,037,527		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	8,026	8,026	1,737,533	-4,403,739	5.00
7.00 00700	OPERATION OF PLANT	4,963	4,963	381,776	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	660	660	0	0	8.00
9.00 00900	HOUSEKEEPING	486	486	349,975	0	9.00
10.00 01000	DIETARY	2,996	2,996	58,223	0	10.00
11.00 01100	CAFETERIA	1,828	1,828	426,605	0	11.00
13.00 01300	NURSING ADMINISTRATION	458	458	553,903	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	692	692	0	0	14.00
15.00 01500	PHARMACY	1,658	1,658	698,568	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,009	1,009	228,742	0	16.00
17.00 01700	SOCIAL SERVICE	248	248	146,873	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	246,796	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	9,067	9,067	2,555,559	0	30.00
31.00 03100	INTENSIVE CARE UNIT	2,619	2,619	738,208	0	31.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
43.00 04300	NURSERY	509	509	31,035	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	4,336	4,336	392,089	0	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	2,083	2,083	24,859	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	161,190	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,553	2,553	930,090	0	54.00
60.00 06000	LABORATORY	1,932	1,932	810,338	0	60.00
65.00 06500	RESPIRATORY THERAPY	443	443	449,688	0	65.00
66.00 06600	PHYSICAL THERAPY	653	653	299,034	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	653	653	93,388	0	67.00
68.00 06800	SPEECH PATHOLOGY	201	201	11,382	0	68.00
69.00 06900	ELECTROCARDIOLOGY	393	393	27,241	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
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	2,628	2,628	725,276	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	51,094	51,094	12,078,371	-4,403,739	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	382	382	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	919	919	0	0	192.00
194.00 07950	FOUNDATION/ MOBS	0	0	2,959,156	0	194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per wkst. B, Part I)	537,411	154,665	4,497,370		202.00
203.00	Unit cost multiplier (wkst. B, Part I)	10.256914	2.951904	0.299076		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 Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)		
		7.00	8.00	9.00	10.00	11.00		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
2.00	00200						2.00	
4.00	00400						4.00	
5.00	00500						5.00	
7.00	00700	39,406					7.00	
8.00	00800	660	23,837				8.00	
9.00	00900	486	2,467	2,345			9.00	
10.00	01000	2,996	622	15	109,518		10.00	
11.00	01100	1,828	0	7	96,366	1,470	11.00	
13.00	01300	458	0	52	0	78	13.00	
14.00	01400	692	0	20	0	0	14.00	
15.00	01500	1,658	0	24	0	89	15.00	
16.00	01600	1,009	0	16	0	0	16.00	
17.00	01700	248	0	8	0	0	17.00	
19.00	01900	0	0	0	0	0	19.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	9,067	7,256	940	11,064	462	30.00	
31.00	03100	2,619	2,325	155	2,088	121	31.00	
33.00	03300	0	0	0	0	0	33.00	
43.00	04300	509	0	14	0	10	43.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	4,336	1,882	245	0	62	50.00	
52.00	05200	2,083	0	6	0	4	52.00	
53.00	05300	0	0	2	0	10	53.00	
54.00	05400	2,553	2,132	115	0	166	54.00	
60.00	06000	1,932	0	110	0	175	60.00	
65.00	06500	443	0	30	0	77	65.00	
66.00	06600	653	2,228	43	0	68	66.00	
67.00	06700	653	0	0	0	1	67.00	
68.00	06800	201	0	1	0	0	68.00	
69.00	06900	393	0	0	0	20	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	
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	2,628	3,601	376	0	127	91.00	
92.00	09200						92.00	
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1-117)		38,105	22,513	2,179	109,518	1,470	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	382	0	25	0	0	190.00	
192.00	19200	919	1,324	129	0	0	192.00	
194.00	07950	0	0	12	0	0	194.00	
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers							201.00
202.00	Cost to be allocated (per Wkst. B, Part I)		1,940,291	240,321	677,981	374,788	1,326,318	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)		49.238466	10.081848	289.117697	3.422159	902.257143	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		73,033	10,742	10,858	46,311	71,801	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		1.853347	0.450644	4.630277	0.422862	48.844218	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151317

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

Worksheet B-1

Date/Time Prepared:
6/2/2014 2:04 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	782					13.00
14.00	01400	0	267,952				14.00
15.00	01500	0	0	100			15.00
16.00	01600	0	0	0	590		16.00
17.00	01700	0	0	0	0	162	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	462	0	0	121	127	30.00
31.00	03100	121	0	0	19	23	31.00
33.00	03300	0	0	0	0	0	33.00
43.00	04300	10	0	0	6	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	62	0	0	24	6	50.00
52.00	05200	0	0	0	2	4	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	0	0	107	0	54.00
60.00	06000	0	0	0	25	0	60.00
65.00	06500	0	0	0	1	0	65.00
66.00	06600	0	0	0	4	0	66.00
67.00	06700	0	0	0	1	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	3	0	69.00
71.00	07100	0	265,092	0	0	0	71.00
72.00	07200	0	2,860	0	0	0	72.00
73.00	07300	0	0	100	4	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	127	0	0	82	2	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		782	267,952	100	399	162	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	191	0	192.00
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		1,106,968	441,094	1,382,396	450,241	245,593	202.00
203.00		1,415.560102	1.646168	13,823.960000	763.120339	1,516.006173	203.00
204.00		14,800	12,063	34,108	16,797	4,664	204.00
205.00		18.925831	0.045019	341.080000	28.469492	28.790123	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151317

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

Worksheet B-1

Date/Time Prepared:
6/2/2014 2:04 pm

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
GENERAL SERVICE COST CENTERS		19.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS		30.00
31.00	03100 INTENSIVE CARE UNIT		31.00
33.00	03300 BURN INTENSIVE CARE UNIT		33.00
43.00	04300 NURSERY		43.00
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	100	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
OUTPATIENT SERVICE COST CENTERS			
91.00	09100 EMERGENCY	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	100	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950 FOUNDATION/ MOBS	0	194.00
200.00	Cross Foot Adjustments		200.00
201.00	Negative Cost Centers		201.00
202.00	Cost to be allocated (per wkst. B, Part I)	381,721	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	3,817.210000	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	1,471	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	14.710000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151317

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

Worksheet C
Part I
Date/Time Prepared:
6/2/2014 2:04 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs
				Total Costs	RCE Disallowance	
				1.00	2.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	6,349,067		6,349,067	0	0 30.00
31.00	03100 INTENSIVE CARE UNIT	1,754,364		1,754,364	0	0 31.00
33.00	03300 BURN INTENSIVE CARE UNIT	0		0	0	0 33.00
43.00	04300 NURSERY	113,051		113,051	0	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1,394,816		1,394,816	0	0 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	188,241		188,241	0	0 52.00
53.00	05300 ANESTHESIOLOGY	649,441		649,441	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,834,859		2,834,859	0	0 54.00
60.00	06000 LABORATORY	3,467,769		3,467,769	0	0 60.00
65.00	06500 RESPIRATORY THERAPY	886,392	0	886,392	0	0 65.00
66.00	06600 PHYSICAL THERAPY	628,591	0	628,591	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	188,532	0	188,532	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	30,952	0	30,952	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	115,868		115,868	0	0 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	752,010		752,010	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	8,113		8,113	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,013,373		3,013,373	0	0 73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	2,270,892		2,270,892	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,412,264		1,412,264	0	0 92.00
200.00	Subtotal (see instructions)	26,058,595	0	26,058,595	0	0 200.00
201.00	Less Observation Beds	1,412,264		1,412,264	0	0 201.00
202.00	Total (see instructions)	24,646,331	0	24,646,331	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151317

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

Worksheet C
Part I
Date/Time Prepared:
6/2/2014 2:04 pm

Cost Center Description		Charges			Hospital	Cost	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)				Cost or Other Ratio
		6.00	7.00	8.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,285,465		3,285,465			30.00
31.00	03100	INTENSIVE CARE UNIT	1,061,395		1,061,395			31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0			33.00
43.00	04300	NURSERY	162,400		162,400			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	686,563	2,130,890	2,817,453	0.495063	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	176,168	155,951	332,119	0.566788	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	247,862	515,159	763,021	0.851144	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,261,151	13,452,062	14,713,213	0.192674	0.000000	54.00
60.00	06000	LABORATORY	1,715,437	10,920,173	12,635,610	0.274444	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	594,755	253,787	848,542	1.044606	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	121,200	1,401,819	1,523,019	0.412727	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	38,612	293,026	331,638	0.568487	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	32,742	29,066	61,808	0.500777	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	484,091	1,695,971	2,180,062	0.053149	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,302,602	932,867	2,235,469	0.336399	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	47,852	47,852	0.169544	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,391,866	5,658,308	8,050,174	0.374324	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	217,274	4,790,653	5,007,927	0.453459	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,212,625	1,212,625	1.164634	0.000000	92.00
200.00		Subtotal (see instructions)	13,779,583	43,490,209	57,269,792			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	13,779,583	43,490,209	57,269,792			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151317

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

Worksheet C
Part I
Date/Time Prepared:
6/2/2014 2:04 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
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
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: 151317

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

Worksheet C
Part I
Date/Time Prepared:
6/2/2014 2:04 pm

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Hospital		Total Costs	
			Costs			
			Total Costs	RCE Disallowance		
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	6,349,067		6,349,067	0	6,349,067	30.00
31.00 03100 INTENSIVE CARE UNIT	1,754,364		1,754,364	0	1,754,364	31.00
33.00 03300 BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
43.00 04300 NURSERY	113,051		113,051	0	113,051	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1,394,816		1,394,816	0	1,394,816	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	188,241		188,241	0	188,241	52.00
53.00 05300 ANESTHESIOLOGY	649,441		649,441	0	649,441	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,834,859		2,834,859	0	2,834,859	54.00
60.00 06000 LABORATORY	3,467,769		3,467,769	0	3,467,769	60.00
65.00 06500 RESPIRATORY THERAPY	886,392	0	886,392	0	886,392	65.00
66.00 06600 PHYSICAL THERAPY	628,591	0	628,591	0	628,591	66.00
67.00 06700 OCCUPATIONAL THERAPY	188,532	0	188,532	0	188,532	67.00
68.00 06800 SPEECH PATHOLOGY	30,952	0	30,952	0	30,952	68.00
69.00 06900 ELECTROCARDIOLOGY	115,868		115,868	0	115,868	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	752,010		752,010	0	752,010	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	8,113		8,113	0	8,113	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3,013,373		3,013,373	0	3,013,373	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	2,270,892		2,270,892	0	2,270,892	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,412,264		1,412,264	0	1,412,264	92.00
200.00 Subtotal (see instructions)	26,058,595	0	26,058,595	0	26,058,595	200.00
201.00 Less Observation Beds	1,412,264		1,412,264		1,412,264	201.00
202.00 Total (see instructions)	24,646,331	0	24,646,331	0	24,646,331	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151317

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

Worksheet C
Part I
Date/Time Prepared:
6/2/2014 2:04 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,285,465		3,285,465		30.00
31.00	03100	INTENSIVE CARE UNIT	1,061,395		1,061,395		31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0		33.00
43.00	04300	NURSERY	162,400		162,400		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	686,563	2,130,890	2,817,453	0.495063	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	176,168	155,951	332,119	0.566788	52.00
53.00	05300	ANESTHESIOLOGY	247,862	515,159	763,021	0.851144	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,261,151	13,452,062	14,713,213	0.192674	54.00
60.00	06000	LABORATORY	1,715,437	10,920,173	12,635,610	0.274444	60.00
65.00	06500	RESPIRATORY THERAPY	594,755	253,787	848,542	1.044606	65.00
66.00	06600	PHYSICAL THERAPY	121,200	1,401,819	1,523,019	0.412727	66.00
67.00	06700	OCCUPATIONAL THERAPY	38,612	293,026	331,638	0.568487	67.00
68.00	06800	SPEECH PATHOLOGY	32,742	29,066	61,808	0.500777	68.00
69.00	06900	ELECTROCARDIOLOGY	484,091	1,695,971	2,180,062	0.053149	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,302,602	932,867	2,235,469	0.336399	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	47,852	47,852	0.169544	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,391,866	5,658,308	8,050,174	0.374324	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	217,274	4,790,653	5,007,927	0.453459	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,212,625	1,212,625	1.164634	92.00
200.00		Subtotal (see instructions)	13,779,583	43,490,209	57,269,792		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	13,779,583	43,490,209	57,269,792		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151317

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

Worksheet C
Part I
Date/Time Prepared:
6/2/2014 2:04 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
33.00	03300 BURN INTENSIVE CARE UNIT				33.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151317

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

Worksheet D
Part II
Date/Time Prepared:
6/2/2014 2:04 pm

Cost Center Description		Title XVIII			Hospital	Cost		
		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	75,895	2,817,453	0.026937	239,316	6,446	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	32,050	332,119	0.096502	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,492	763,021	0.001955	76,775	150	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	244,566	14,713,213	0.016622	875,332	14,550	54.00
60.00	06000	LABORATORY	51,063	12,635,610	0.004041	1,209,454	4,887	60.00
65.00	06500	RESPIRATORY THERAPY	13,629	848,542	0.016062	327,104	5,254	65.00
66.00	06600	PHYSICAL THERAPY	16,390	1,523,019	0.010762	66,743	718	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,509	331,638	0.031688	20,004	634	67.00
68.00	06800	SPEECH PATHOLOGY	3,113	61,808	0.050366	25,347	1,277	68.00
69.00	06900	ELECTROCARDIOLOGY	7,275	2,180,062	0.003337	457,566	1,527	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,151	2,235,469	0.005883	86,993	512	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	142	47,852	0.002967	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,497	8,050,174	0.005031	2,148,477	10,809	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	60,255	5,007,927	0.012032	6,588	79	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,212,625	0.000000	0	0	92.00
200.00		Total (lines 50-199)	570,027	52,760,532		5,539,699	46,843	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151317

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

Worksheet D
Part IV
Date/Time Prepared:
6/2/2014 2:04 pm

Cost Center Description		Title XVIII				Hospital	Cost
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	381,721	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
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	381,721	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151317

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

Worksheet D
Part IV
Date/Time Prepared:
6/2/2014 2:04 pm

Cost Center Description			Title XVIII				Hospital	
			Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)	Outpatient Ratio of Cost to Charges (col. 6 + col. 7)	Inpatient Program Charges	Cost
			6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,817,453	0.000000	0.000000	239,316	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	332,119	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	763,021	0.500276	0.000000	76,775	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,713,213	0.000000	0.000000	875,332	54.00
60.00	06000	LABORATORY	0	12,635,610	0.000000	0.000000	1,209,454	60.00
65.00	06500	RESPIRATORY THERAPY	0	848,542	0.000000	0.000000	327,104	65.00
66.00	06600	PHYSICAL THERAPY	0	1,523,019	0.000000	0.000000	66,743	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	331,638	0.000000	0.000000	20,004	67.00
68.00	06800	SPEECH PATHOLOGY	0	61,808	0.000000	0.000000	25,347	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,180,062	0.000000	0.000000	457,566	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,235,469	0.000000	0.000000	86,993	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	47,852	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,050,174	0.000000	0.000000	2,148,477	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	5,007,927	0.000000	0.000000	6,588	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,212,625	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	52,760,532			5,539,699	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151317

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

Worksheet D
Part IV
Date/Time Prepared:
6/2/2014 2:04 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
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0
53.00	05300 ANESTHESIOLOGY	38,409	0	0	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0
60.00	06000 LABORATORY	0	0	0	0
65.00	06500 RESPIRATORY THERAPY	0	0	0	0
66.00	06600 PHYSICAL THERAPY	0	0	0	0
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0
68.00	06800 SPEECH PATHOLOGY	0	0	0	0
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
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0	0	0	0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0
200.00	Total (lines 50-199)	38,409	0	0	0

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151317

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

Worksheet D
Part IV
Date/Time Prepared:
6/2/2014 2:04 pm

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Hospital	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
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00	Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151317

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

Worksheet D
Part V
Date/Time Prepared:
6/2/2014 2:04 pm

Cost Center Description		Title XVIII				Hospital	Cost	
		Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Charges		PPS Services (see inst.)		
				Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
1.00	2.00	3.00	4.00	5.00				
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.495063	0	1,019,589	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.566788	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.851144	0	126,251	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.192674	0	5,226,624	0	0	54.00
60.00	06000	LABORATORY	0.274444	0	5,310,893	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.044606	0	75,943	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.412727	0	565,257	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.568487	0	92,937	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.500777	0	11,213	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.053149	0	900,170	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.336399	0	355,359	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.169544	0	40,470	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.374324	0	2,631,358	467	0	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.453459	0	1,689,532	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.164634	0	385,650	0	0	92.00
200.00		Subtotal (see instructions)		0	18,431,246	467	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0	0	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	18,431,246	467	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151317

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

Worksheet D
Part V
Date/Time Prepared:
6/2/2014 2:04 pm

		Title XVIII		Hospital	Cost
Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	504,761	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	107,458	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,007,035	0	54.00
60.00	06000	LABORATORY	1,457,543	0	60.00
65.00	06500	RESPIRATORY THERAPY	79,331	0	65.00
66.00	06600	PHYSICAL THERAPY	233,297	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	52,833	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,615	0	68.00
69.00	06900	ELECTROCARDIOLOGY	47,843	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	119,542	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,861	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	984,980	175	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	766,133	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	449,141	0	92.00
200.00		Subtotal (see instructions)	5,822,373	175	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	5,822,373	175	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151317

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

Worksheet D
Part V
Date/Time Prepared:
6/2/2014 2:04 pm

Component CCN: 152317

Title XVIII Swing Beds - SNF

Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.495063	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.566788	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.851144	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.192674	0	0	0	0	54.00
60.00 06000 LABORATORY	0.274444	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	1.044606	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.412727	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.568487	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.500777	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.053149	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.336399	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.169544	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.374324	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0.453459	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.164634	0	0	0	0	92.00
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: 151317

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

Worksheet D Part V

Component CCN: 152317

Date/Time Prepared: 6/2/2014 2:04 pm

Cost Center Description		Costs		Swing Beds - SNF	Cost
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000 LABORATORY	0	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
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

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151317

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

Worksheet D-1

Date/Time Prepared:
6/2/2014 2:04 pm

Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,920 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,737 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			2,871 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			154 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			29 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			1,990 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)			154 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			126.36 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			6,349,067 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)			3,664 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)			254,806 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			6,094,261 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			6,094,261 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)			1,630.79 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			3,245,272 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)			3,245,272 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151317

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

Worksheet D-1

Date/Time Prepared:
6/2/2014 2:04 pm

Cost Center Description	Title XVIII			Hospital	Program Cost	Cost
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	(col. 3 x col. 4)	
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	1,754,364	462	3,797.32	374	1,420,198	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	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)					1,938,508	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,603,978	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)					251,142	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)					251,142	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)					866	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,630.79	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,412,264	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151317

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

Worksheet D-1

Date/Time Prepared:
6/2/2014 2:04 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

Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,920 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,737 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			2,871 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			154 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			29 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)			46 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)			140 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			6,349,067 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)			251,286 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			6,097,781 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			6,097,781 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)			1,631.73 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			75,060 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)			75,060 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151317

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

Worksheet D-1

Date/Time Prepared:
6/2/2014 2:04 pm

Cost Center Description	Title XIX			Hospital		Cost	
	Total	Total	Average Per	Program Days	Program Cost		
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	113,051	140	807.51	4.00	5.00	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	1,754,364	462	3,797.32	13	49,365		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT	0	0	0.00	0	0		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)					282,458		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					406,883		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)						866	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,631.73		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,413,078		89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151317

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

worksheet D-1

Date/Time Prepared:
6/2/2014 2:04 pm

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151317

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

Worksheet D-3

Date/Time Prepared:
6/2/2014 2:04 pm

Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		2,320,107		30.00
31.00	03100 INTENSIVE CARE UNIT		722,915		31.00
33.00	03300 BURN INTENSIVE CARE UNIT		0		33.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.495063	239,316	118,476	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.566788	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.851144	76,775	65,347	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.192674	875,332	168,654	54.00
60.00	06000 LABORATORY	0.274444	1,209,454	331,927	60.00
65.00	06500 RESPIRATORY THERAPY	1.044606	327,104	341,695	65.00
66.00	06600 PHYSICAL THERAPY	0.412727	66,743	27,547	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.568487	20,004	11,372	67.00
68.00	06800 SPEECH PATHOLOGY	0.500777	25,347	12,693	68.00
69.00	06900 ELECTROCARDIOLOGY	0.053149	457,566	24,319	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.336399	86,993	29,264	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.169544	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.374324	2,148,477	804,227	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.453459	6,588	2,987	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.164634	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		5,539,699	1,938,508	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)		5,539,699		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151317	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3	
		Component CCN: 15z317		Date/Time Prepared: 6/2/2014 2:04 pm	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT		2,796	31.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.495063	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.566788	0	52.00
53.00	05300	ANESTHESIOLOGY	0.851144	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.192674	8,661	54.00
60.00	06000	LABORATORY	0.274444	19,636	60.00
65.00	06500	RESPIRATORY THERAPY	1.044606	12,640	65.00
66.00	06600	PHYSICAL THERAPY	0.412727	27,835	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.568487	11,826	67.00
68.00	06800	SPEECH PATHOLOGY	0.500777	874	68.00
69.00	06900	ELECTROCARDIOLOGY	0.053149	5,145	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.336399	26,534	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.169544	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.374324	59,600	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.453459	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.164634	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		172,751	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)		172,751	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151317	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 6/2/2014 2:04 pm
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Cost Center Description		Title XIX	Hospital	Cost
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		326,415	30.00
31.00	03100 INTENSIVE CARE UNIT		29,025	31.00
33.00	03300 BURN INTENSIVE CARE UNIT		0	33.00
43.00	04300 NURSERY		89,320	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.495063	120,985	59,895 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.566788	41,546	23,548 52.00
53.00	05300 ANESTHESIOLOGY	0.851144	2,975	2,532 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.192674	103,307	19,905 54.00
60.00	06000 LABORATORY	0.274444	145,440	39,915 60.00
65.00	06500 RESPIRATORY THERAPY	1.044606	32,457	33,905 65.00
66.00	06600 PHYSICAL THERAPY	0.412727	1,578	651 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.568487	350	199 67.00
68.00	06800 SPEECH PATHOLOGY	0.500777	504	252 68.00
69.00	06900 ELECTROCARDIOLOGY	0.053149	10,356	550 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.336399	58,459	19,666 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.169544	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.374324	183,789	68,797 73.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0.453459	27,881	12,643 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.164634	0	0 92.00
200.00	Total (sum of lines 50-94 and 96-98)		729,627	282,458 200.00
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)		729,627	282,458 202.00

Provider CCN: 151317	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 6/2/2014 2:04 pm
Title XVIII	Hospital	Cost

		1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)	5,822,548	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,822,548	11.00
COMPUTATION OF LESSER OF COST OR CHARGES			
Reasonable charges			
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
Customary charges			
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	5,880,773	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)	33,709	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,639,826	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	3,207,238	27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,207,238	30.00
31.00	Primary payer payments	1,886	31.00
32.00	Subtotal (line 30 minus line 31)	3,205,352	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)	652,273	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	574,000	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	467,622	36.00
37.00	Subtotal (see instructions)	3,779,352	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00		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)	3,779,352	40.00
40.01	Sequestration adjustment (see instructions)	57,068	40.01
41.00	Interim payments	3,660,122	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	62,162	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	167,573	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	
112.00	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: 151317

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

Worksheet E-1
Part I
Date/Time Prepared:
6/2/2014 2:04 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				
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		6,847,996		3,660,122
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)				
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	07/11/2013	269,900		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		269,900		0
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)		7,117,896		3,660,122
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)				
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		0		62,162
6.02	SETTLEMENT TO PROGRAM		899,253		0
7.00	Total Medicare program liability (see instructions)		6,218,643		3,722,284
				Contractor Number	NPR Date (Mo/Day/Yr)
				0	1.00 2.00
8.00	Name of Contractor				

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151317
Component CCN: 15Z317

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

Worksheet E-1
Part I
Date/Time Prepared:
6/2/2014 2:04 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		337,799		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)		337,799		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		20,404		0		6.02
7.00	Total Medicare program liability (see instructions)		317,395		0		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 151317

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

Worksheet E-1
Part II
Date/Time Prepared:
6/2/2014 2:04 pm

		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from wkst S-3, Part I column 15 line 14			1,032 1.00
2.00	Medicare days from wkst S-3, Part I, column 6 sum of lines 1, 8-12			2,364 2.00
3.00	Medicare HMO days from wkst S-3, Part I, column 6. line 2			0 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			3,333 4.00
5.00	Total hospital charges from wkst C, Part I, column 8 line 200			57,269,792 5.00
6.00	Total hospital charity care charges from wkst S-10, column 3 line 20			2,068,428 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology worksheet S-2, Part I line 168			211,750 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			198,156 8.00
9.00	Sequestration adjustment amount (see instructions)			3,963 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			194,193 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			194,193 32.00
				overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			0 108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151317
Component CCN: 152317

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

Worksheet E-2
Date/Time Prepared:
6/2/2014 2:04 pm

		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)	253,653	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)	71,124	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	154	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)	324,777	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	324,777	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)	324,777	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	2,516	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)	322,261	0	15.00
16.00		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)	322,261	0	19.00
19.01	Sequestration adjustment (see instructions)	4,866	0	19.01
20.00	Interim payments	337,799	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	-20,404	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	10,998	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151317	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part V Date/Time Prepared: 6/2/2014 2:04 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			6,603,978 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)			6,603,978 4.00
5.00	Primary payer payments			13,750 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			6,656,268 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)			6,656,268 19.00
20.00	Deductibles (exclude professional component)			512,664 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			6,143,604 22.00
23.00	Coinsurance			2,960 23.00
24.00	Subtotal (line 22 minus line 23)			6,140,644 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			196,977 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			173,340 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			61,994 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			6,313,984 28.00
29.00				0 29.00
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (line 28, plus or minus lines 29)			6,313,984 30.00
30.01	Sequestration adjustment (see instructions)			95,341 30.01
31.00	Interim payments			7,117,896 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			-899,253 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			221,143 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 151317

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

Worksheet E-3
Part VII
Date/Time Prepared:
6/2/2014 2:04 pm

		Title XIX		Hospital		Cost	
				Inpatient	Outpatient		
				1.00	2.00		
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES							
COMPUTATION OF NET COST OF COVERED SERVICES							
1.00	Inpatient hospital/SNF/NF services			406,883			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)			406,883		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)			406,883		0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES							
Reasonable Charges							
8.00	Routine service charges			444,760			8.00
9.00	Ancillary service charges			729,627		0	9.00
10.00	Organ acquisition charges, net of revenue			0			10.00
11.00	Incentive from target amount computation			0			11.00
12.00	Total reasonable charges (sum of lines 8 through 11)			1,174,387		0	12.00
CUSTOMARY CHARGES							
13.00	Amount actually collected from patients liable for payment for services on a charge basis			0		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)			0.000000		0.000000	15.00
16.00	Total customary charges (see instructions)			1,174,387		0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			767,504		0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			0		0	18.00
19.00	Interns and Residents (see instructions)			0		0	19.00
20.00	Cost of Teaching Physicians (see instructions)			0		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)			406,883		0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.							
22.00	Other than outlier payments			0		0	22.00
23.00	Outlier payments			0		0	23.00
24.00	Program capital payments			0			24.00
25.00	Capital exception payments (see instructions)			0			25.00
26.00	Routine and Ancillary service other pass through costs			0		0	26.00
27.00	Subtotal (sum of lines 22 through 26)			0		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)			0		0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)			406,883		0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT							
30.00	Excess of reasonable cost (from line 18)			0		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			406,883		0	31.00
32.00	Deductibles			0		0	32.00
33.00	Coinsurance			0		0	33.00
34.00	Allowable bad debts (see instructions)			0		0	34.00
35.00	Utilization review			0			35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)			406,883		0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0		0	37.00
38.00	Subtotal (line 36 ± line 37)			406,883		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)			406,883		0	40.00
41.00	Interim payments			406,883		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		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: 151317

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

worksheet G

Date/Time Prepared:
6/2/2014 2:04 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	1,781,482	0	0	0	1.00
2.00	Temporary investments	2,066,610	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,403,817	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	313,320	0	0	0	7.00
8.00	Prepaid expenses	100,878	0	0	0	8.00
9.00	Other current assets	639,148	0	0	0	9.00
10.00	Due from other funds	1,441,209	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	13,746,464	0	0	0	11.00
FIXED ASSETS						
12.00	Land	759,198	0	0	0	12.00
13.00	Land improvements	689,896	0	0	0	13.00
14.00	Accumulated depreciation	-422,725	0	0	0	14.00
15.00	Buildings	10,689,160	0	0	0	15.00
16.00	Accumulated depreciation	-6,296,657	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	4,240,919	0	0	0	19.00
20.00	Accumulated depreciation	-951,418	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	4,654,019	0	0	0	23.00
24.00	Accumulated depreciation	-3,037,095	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)	10,325,297	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	724,651	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	724,651	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	24,796,412	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,341,730	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,101,744	0	0	0	38.00
39.00	Payroll taxes payable	62,507	0	0	0	39.00
40.00	Notes and loans payable (short term)	178,008	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	556,201	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,240,190	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	8,766,992	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	8,766,992	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	12,007,182	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	12,789,230				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)	12,789,230	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	24,796,412	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151317

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

Worksheet G-1

Date/Time Prepared:
6/2/2014 2:04 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		26,923,510		0		1.00
2.00	Net income (loss) (from wkst. G-3, line 29)		-11,019,638				2.00
3.00	Total (sum of line 1 and line 2)		15,903,872		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)		15,903,872		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	CHANGE IN PRIOR YEAR RE	3,114,642		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)		3,114,642		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		12,789,230		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00	CHANGE IN PRIOR YEAR RE		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: 151317

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
6/2/2014 2:04 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,407,081		3,407,081	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,407,081		3,407,081	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	1,061,395		1,061,395	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT	0		0	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)	1,061,395		1,061,395	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,468,476		4,468,476	17.00
18.00	Ancillary services	9,289,185	47,348,453	56,637,638	18.00
19.00	Outpatient services	0	0	0	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				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	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)	13,757,661	47,348,453	61,106,114	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		29,346,031		29.00
30.00	BAD DEBT	17,550,574			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)		17,550,574		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)		46,896,605		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151317

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

Worksheet G-3

Date/Time Prepared:
6/2/2014 2:04 pm

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	61,106,114	1.00
2.00	Less contractual allowances and discounts on patients' accounts	28,421,528	2.00
3.00	Net patient revenues (line 1 minus line 2)	32,684,586	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	46,896,605	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-14,212,019	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	10,030	6.00
7.00	Income from investments	47,844	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	307,832	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	5,845	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	150,749	22.00
23.00	Governmental appropriations	0	23.00
24.00	GRANTS	25,067	24.00
24.01	MISC INCOME	572,630	24.01
24.02	DSH PAYMENT	2,061,251	24.02
24.03	CPR TRAINING	1,002	24.03
24.04	GIFT CARD SALES	10,131	24.04
24.05		0	24.05
25.00	Total other income (sum of lines 6-24)	3,192,381	25.00
26.00	Total (line 5 plus line 25)	-11,019,638	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-11,019,638	29.00