

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).
 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY
 Provider CCN: 153042
 Period: From 04/18/2013 To 12/31/2013
 Worksheet 5
 Parts I-III
 Date/Time Prepared: 5/20/2014 4:24 pm
 FORM APPROVED
 OMB NO. 0938-0050

PART I - COST REPORT STATUS

Provider use only
 1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.
 Contractor use only
 5. Cost Report Status
 (1) As Submitted
 (2) Settled without Audit
 (3) Settled with Audit
 (4) Reopened
 (5) Amended
 6. Date Received:
 7. Contractor No.
 8. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN
 10. NPR Date:
 11. Contractor's Vendor Code: 4
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.
 Date: 5/20/2014 Time: 4:24 pm

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 Lafayette Regional Rehabilitation Hospital (153042) for the cost reporting period beginning 04/18/2013 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) Kristi Duncan
 Officer or Administrator of Provider(s)
Vice President
 Title
5/21/14
 Date

Encryption Information

ECR: Date: 5/20/2014 Time: 4:24 pm
 73IL.M5Xwi9AWfPziIUIYWTsplhdv0
 dQoJM02wjzPX5WYBBT7jddqxYkre3j
 AjeJ0zfdxA0dj2CO
 PI: Date: 5/20/2014 Time: 4:24 pm
 ZIPYe0FN07tgz99JfENalah1PK73k0
 iQSa00yng2.dp6sbh:5rEafODCAv61
 FJm6Qlodky0flxbu

	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	101,578	0	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
200.00 Total	0	101,578	0	0	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.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 153042	Period: From 04/18/2013 To 12/31/2013	Worksheet S Parts I-III Date/Time Prepared: 5/20/2014 4:24 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/20/2014 Time: 4:24 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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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 Lafayette Regional Rehabilitation Hospital (153042) for the cost reporting period beginning 04/18/2013 and ending 12/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	101,578	0	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
200.00 Total	0	101,578	0	0	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: 153042		Period: From 04/18/2013 To 12/31/2013		Worksheet S-2 Part I Date/Time Prepared: 5/20/2014 4:21 pm				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 950 Park East Blvd			PO Box:							1.00	
2.00	City: Lafayette			State: IN		Zip Code: 47905		County: Tippecanoe			2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
				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			Lafayette Regional Rehabilitation Hospital	153042	29140	5	04/18/2013	N	P	P	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:		To:			
							1.00		2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						04/18/2013		12/31/2013		20.00	
21.00	Type of Control (see instructions)								4		21.00	
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N		N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)										22.01	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.								2 N		23.00	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid 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.			325	13	0	0	0	0		25.00	
							Urban/Rural S		Date of Geogr			
							1.00		2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.								1		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.								1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.								0		35.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 153042	Period: From 04/18/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/20/2014 4:21 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					39.00
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.					58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06
		Program Name 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

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	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
	1.00	2.00	3.00	4.00		
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.		0.00	0.00	61.20	
				1.00		
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)			0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)			0.00	62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)			N	63.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
64.00	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. 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
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	3.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
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
					1.00	2.00	3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y			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)			N	N	0	76.00
					1.00		
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N	80.00
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00
					V	XIX	
					1.00	2.00	
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N		N	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	95.00
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)?			N			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)						106.00

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		V	XIX		
		1.00	2.00		
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				109.00
		1.00	2.00	3.00	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		0		118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	0	
		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.		N		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y	329003	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 153042	Period: From 04/18/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/20/2014 4:21 pm
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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: ERNEST HEALTH INC	Contractor's Name: NOVITAS SOLUTIONS		Contractor's Number: 04011		141.00
142.00	Street: 7770 JEFFERSON ST NE STE 320	PO Box:				142.00
143.00	City: ALBUQUERQUE	State: NM		Zip Code: 87109		143.00

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

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

		1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		0.00
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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 153042	Period: From 04/18/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/20/2014 4:21 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	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.			N	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/05/2014	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 153042 Period: From 04/18/2013 To 12/31/2013 Worksheet S-2 Part II Date/Time Prepared: 5/20/2014 4:21 pm

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
1.00					
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				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.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				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.				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				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				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.				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.				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.				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.				35.00
Y/N Date					
1.00 2.00					
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				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.				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.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				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.	Mary		Pitcock	41.00
42.00	Enter the employer/company name of the cost report preparer.	ERNEST HEALTH INC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	505-798-3179		marykay@ernesthealth.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)	05/05/2014	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.	SR. REIMBURSEMENT ANALYST	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet S-3
Part I
Date/Time Prepared:
5/20/2014 4:21 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	40	10,320	0.00	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)		40	10,320	0.00	0	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)		40	10,320	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	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)		40				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: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet S-3
Part I
Date/Time Prepared:
5/20/2014 4:21 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)	2,947	325	4,498			1.00
2.00 HMO and other (see instructions)	133	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	2,947	325	4,498			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)	2,947	325	4,498	0.00	116.93	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	0	0	0	0.00	0.00	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						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	116.93	27.00
28.00 Observation Bed Days		0	0			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet S-3
Part I
Date/Time Prepared:
5/20/2014 4:21 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	233	16	341	1.00
2.00 HMO and other (see instructions)				10			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	233	16	341		14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY	0.00						19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet A
Date/Time Prepared:
5/20/2014 4:21 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100		1,677,080	1,677,080	7,780	1,684,860	1.00	
2.00	00200		364,735	364,735	1,764	366,499	2.00	
3.00	00300		-16,421	-16,421	-9,544	-25,965	3.00	
4.00	00400	288,575	402,944	691,519	0	691,519	4.00	
5.00	00500	768,777	755,199	1,523,976	0	1,523,976	5.00	
7.00	00700	64,919	237,402	302,321	1,010	303,331	7.00	
8.00	00800	0	24,945	24,945	0	24,945	8.00	
9.00	00900	118,676	98,123	216,799	0	216,799	9.00	
10.00	01000	171,878	189,802	361,680	0	361,680	10.00	
13.00	01300	193,071	21,836	214,907	0	214,907	13.00	
16.00	01600	37,721	14,110	51,831	0	51,831	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	1,108,997	112,756	1,221,753	0	1,221,753	30.00	
44.00	04400	0	0	0	0	0	44.00	
ANCILLARY SERVICE COST CENTERS								
54.00	05400	0	133	133	0	133	54.00	
60.00	06000	0	58,050	58,050	0	58,050	60.00	
65.00	06500	87,937	13,878	101,815	0	101,815	65.00	
66.00	06600	332,091	57,695	389,786	-31,433	358,353	66.00	
67.00	06700	272,393	24,893	297,286	23,880	321,166	67.00	
68.00	06800	95,545	9,444	104,989	7,553	112,542	68.00	
71.00	07100	20,340	116,529	136,869	-1,010	135,859	71.00	
73.00	07300	228,645	148,600	377,245	0	377,245	73.00	
74.00	07400	0	0	0	0	0	74.00	
76.00	03950	0	0	0	0	0	76.00	
OUTPATIENT SERVICE COST CENTERS								
93.00	04950	0	0	0	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	0	0	0	0	0	95.00	
SPECIAL PURPOSE COST CENTERS								
117.00	06950	0	0	0	0	0	117.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)		3,789,565	4,311,733	8,101,298	0	8,101,298	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	0	0	0	0	0	192.00	
194.00	07950	0	0	0	0	0	194.00	
194.01	07951	0	0	0	0	0	194.01	
200.00	TOTAL (SUM OF LINES 118-199)		3,789,565	4,311,733	8,101,298	0	8,101,298	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet A
Date/Time Prepared:
5/20/2014 4:21 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,409,224	275,636	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	16,209	382,708	2.00
3.00	00300	OTHER CAP REL COSTS	25,965	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	52,208	743,727	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	354,632	1,878,608	5.00
7.00	00700	OPERATION OF PLANT	-12,285	291,046	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	24,945	8.00
9.00	00900	HOUSEKEEPING	0	216,799	9.00
10.00	01000	DIETARY	-20,139	341,541	10.00
13.00	01300	NURSING ADMINISTRATION	0	214,907	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-127	51,704	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,221,753	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,812	2,945	54.00
60.00	06000	LABORATORY	0	58,050	60.00
65.00	06500	RESPIRATORY THERAPY	0	101,815	65.00
66.00	06600	PHYSICAL THERAPY	-77	358,276	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	321,166	67.00
68.00	06800	SPEECH PATHOLOGY	0	112,542	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-10	135,849	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	377,245	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
SPECIAL PURPOSE COST CENTERS					
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-990,036	7,111,262	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	MARKETING	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.01
200.00		TOTAL (SUM OF LINES 118-199)	-990,036	7,111,262	200.00

Provider CCN: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet A-6
Date/Time Prepared:
5/20/2014 4:21 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - RCLS PCT THERAPY					
1.00	OCCUPATIONAL THERAPY	67.00	21,587	2,293	1.00
2.00	SPEECH PATHOLOGY	68.00	6,828	725	2.00
	TOTALS		28,415	3,018	
B - RCLS PLANT OPS EXP					
1.00	OPERATION OF PLANT	7.00	0	1,010	1.00
	TOTALS		0	1,010	
500.00	Grand Total: Increases		28,415	4,028	500.00

RECLASSIFICATIONS

Provider CCN: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet A-6

Date/Time Prepared:
5/20/2014 4:21 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - RCLS PCT THERAPY						
1.00	PHYSICAL THERAPY	66.00	28,415	3,018	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		28,415	3,018		
B - RCLS PLANT OPS EXP						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,010	0	1.00
	TOTALS		0	1,010		
500.00	Grand Total: Decreases		28,415	4,028		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet A-7
Part I
Date/Time Prepared:
5/20/2014 4:21 pm

	Beginning Balances	Acquisitions			Disposals and Retirements		
		Purchases	Donation	Total			
		1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	800,183	0	800,183	0	1.00
2.00	Land Improvements	0	41,998	0	41,998	0	2.00
3.00	Buildings and Fixtures	0	11,214,379	0	11,214,379	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	0	2,732,820	0	2,732,820	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	0	14,789,380	0	14,789,380	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	0	14,789,380	0	14,789,380	0	10.00
	Ending Balance		Fully Depreciated Assets				
	6.00		7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	800,183	0				1.00
2.00	Land Improvements	41,998	0				2.00
3.00	Buildings and Fixtures	11,214,379	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	2,732,820	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	14,789,380	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	14,789,380	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet A-7
Part II
Date/Time Prepared:
5/20/2014 4:21 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	CAP REL COSTS-BLDG & FIXT	257,900	0	1,419,180	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	354,173	10,562	0	0	0	2.00
3.00	Total (sum of lines 1-2)	612,073	10,562	1,419,180	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	CAP REL COSTS-BLDG & FIXT	0	1,677,080				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	364,735				2.00
3.00	Total (sum of lines 1-2)	0	2,041,815				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet A-7
Part III
Date/Time Prepared:
5/20/2014 4:21 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	CAP REL COSTS-BLDG & FIXT	12,056,560	0	12,056,560	0.815217	7,780	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,732,820	0	2,732,820	0.184783	1,764	2.00
3.00	Total (sum of lines 1-2)	14,789,380	0	14,789,380	1.000000	9,544	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of col.s. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	7,780	267,856	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	1,764	370,382	10,562	2.00
3.00	Total (sum of lines 1-2)	0	0	9,544	638,238	10,562	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of col.s. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	7,780	0	0	275,636	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,764	0	0	382,708	2.00
3.00	Total (sum of lines 1-2)	0	9,544	0	0	658,344	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet A-8

Date/Time Prepared:
5/20/2014 4:21 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.		
			3.00	4.00	5.00			
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	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)			0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-520		ADMINISTRATIVE & GENERAL	5.00		0	7.00
8.00 Television and radio service (chapter 21)	A	-12,264		OPERATION OF PLANT	7.00		0	8.00
9.00 Parking lot (chapter 21)			0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2		0				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00		0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-879,159					0	12.00
13.00 Laundry and linen service			0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-20,036		DIETARY	10.00		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	-157		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			RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3			PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)				*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant			0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3			OCCUPATIONAL THERAPY	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)				ADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3			SPEECH PATHOLOGY	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00		0	32.00
33.00 INTEREST INCOME	B	-2,114		ADMINISTRATIVE & GENERAL	5.00		0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet A-8

Date/Time Prepared:
5/20/2014 4:21 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
33.01 RADIOLOGY EXP FOR 2013 PAID IN 2014	A	2,812	RADIOLOGY-DIAGNOSTIC	54.00	0 33.01
33.02 MIS INCOME	B	-93	ADMINISTRATIVE & GENERAL	5.00	0 33.02
33.04 PRE-OPENING AMORTIZATION - CAP	A	1,644	CAP REL COSTS-BLDG & FIXT	1.00	9 33.04
33.05 PRE-OPENING AMORTIZATION - A&G	A	61,499	ADMINISTRATIVE & GENERAL	5.00	0 33.05
33.08 ADVERTISING/MARKETING - ADMINISTRATION	A	-167	ADMINISTRATIVE & GENERAL	5.00	0 33.08
33.09 ADVERTISING/MARKETING - MARKETING	A	-34,398	ADMINISTRATIVE & GENERAL	5.00	0 33.09
33.11 ADVERTISING/MARKETING - GENERAL OVER	A	-932	ADMINISTRATIVE & GENERAL	5.00	0 33.11
33.12 ADVERTISING/MARKETING - FOOD SERVICE	A	-19	DIETARY	10.00	0 33.12
33.20 COMMUNITY EVENTS - ADMINISTRATION	A	-700	ADMINISTRATIVE & GENERAL	5.00	0 33.20
33.21 COMMUNITY EVENTS - MARKETING	A	-3,537	ADMINISTRATIVE & GENERAL	5.00	0 33.21
33.23 COMMUNITY EVENTS - GENERAL OVERHEAD	A	-81	ADMINISTRATIVE & GENERAL	5.00	0 33.23
33.24 COMMUNITY EVENTS - PLANT OPERATIONS	A	-21	OPERATION OF PLANT	7.00	0 33.24
33.31 CONTRIBUTIONS / SPONSORSHIPS - ADMIN	A	-2,275	ADMINISTRATIVE & GENERAL	5.00	0 33.31
33.32 CONTRIBUTIONS / SPONSORSHIPS - MARKET	A	-1,077	ADMINISTRATIVE & GENERAL	5.00	0 33.32
33.34 CONTRIBUTIONS / SPONSORSHIPS - GENERAL	A	-4,949	ADMINISTRATIVE & GENERAL	5.00	0 33.34
33.43 FLOWERS & GIFTS - ADMINISTRATION	A	-3,180	ADMINISTRATIVE & GENERAL	5.00	0 33.43
33.63 FRANCHISE FEES/BUSINESS TAXES	A	-840	ADMINISTRATIVE & GENERAL	5.00	0 33.63
33.68 GIVEAWAYS - ADMINISTRATION	A	-150	ADMINISTRATIVE & GENERAL	5.00	0 33.68
33.70 GIVEAWAYS - MARKETING	A	-3,455	ADMINISTRATIVE & GENERAL	5.00	0 33.70
33.76 GIVEAWAYS - FOOD SERVICES	A	-84	DIETARY	10.00	0 33.76
33.79 GIVEAWAYS - MEDICAL RECORDS	A	30	MEDICAL RECORDS & LIBRARY	16.00	0 33.79
33.83 GIVEAWAYS - PHYSICAL THERAPY	A	-77	PHYSICAL THERAPY	66.00	0 33.83
33.95 LATE FEES - GENERAL OVERHEAD	A	-412	ADMINISTRATIVE & GENERAL	5.00	0 33.95
34.06 LATE FEES - CENTRAL SUPPLY	A	-10	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0 34.06
34.09 MARKETING COLLATERAL - MARKETING	A	-5,780	ADMINISTRATIVE & GENERAL	5.00	0 34.09
34.18 MARKETING EXPENSE	A	-53,173	ADMINISTRATIVE & GENERAL	5.00	0 34.18
34.19 MARKETING BENEFITS	A	-2,899	EMPLOYEE BENEFITS	4.00	0 34.19
34.20 TELEPHONE OPERATOR EXPENSE	A	-44,176	ADMINISTRATIVE & GENERAL	5.00	0 34.20
34.21 TELEPHONE BENEFIT EXPENSE	A	-628	EMPLOYEE BENEFITS	4.00	0 34.21
34.22 TELEVISION DEPRECIATION	A	-7,884	CAP REL COSTS-MVBLE EQUIP	2.00	9 34.22
34.23 UNALLOWABLE LOBBYING % OF ASSOC DUES	A	-591	ADMINISTRATIVE & GENERAL	5.00	0 34.23
34.24 ADJ HEALTH/DENTAL INS TO ACTUAL	A	55,735	EMPLOYEE BENEFITS	4.00	0 34.24
34.25 ADJ LIABILITY INS TO ACTUAL	A	-33,258	ADMINISTRATIVE & GENERAL	5.00	0 34.25
34.26 ADJUST TO CORRECT NEGATIVE PROPERTY	A	25,965	OTHER CAP REL COSTS	3.00	0 34.26
34.27 PHYSICIAN CONTRACT	A	-18,625	ADMINISTRATIVE & GENERAL	5.00	0 34.27
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-990,036			50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS
 Provider CCN: 153042
 Period: From 04/18/2013 To 12/31/2013
 Worksheet A-8-1
 Date/Time Prepared: 5/20/2014 4:21 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	1.00	CAP REL COSTS-BLDG & FIXT	HO ALLOC CAP - BUILDING	7,953	0
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO ALLOC CAP - EQUIPMENT	24,093	0
3.00	5.00	ADMINISTRATIVE & GENERAL	HO ALLOC - A & G	579,768	78,993
3.01	5.00	ADMINISTRATIVE & GENERAL	PRE-OPENING AMORTIZATION - H	6,841	0
3.02	1.00	CAP REL COSTS-BLDG & FIXT	PRE-OPENING AMORTIZATION - H	359	0
4.00	1.00	CAP REL COSTS-BLDG & FIXT	RELATED PARTY INTEREST	0	1,419,180
5.00	0			619,014	1,498,173

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

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

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

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

6.00	B		0.00	ERNEST HEALTH	100.00	6.00
7.00	B		0.00	MPT	49.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	FINANCIAL				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: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet A-8-1

Date/Time Prepared:
5/20/2014 4:21 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	7,953	9		1.00
2.00	24,093	9		2.00
3.00	500,775	0		3.00
3.01	6,841	0		3.01
3.02	359	9		3.02
4.00	-1,419,180	11		4.00
5.00	-879,159			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	HOME OFFICE		6.00
7.00	RE INVEST TRUST		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet B
Part I
Date/Time Prepared:
5/20/2014 4:21 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	275,636	275,636			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	382,708		382,708		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	743,727	1,109	1,540	746,376	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	1,878,608	17,956	24,931	163,896	5.00
7.00 00700	OPERATION OF PLANT	291,046	63,391	88,015	13,840	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	24,945	0	0	0	8.00
9.00 00900	HOUSEKEEPING	216,799	1,796	2,494	25,301	9.00
10.00 01000	DIETARY	341,541	25,296	35,123	36,643	10.00
13.00 01300	NURSING ADMINISTRATION	214,907	2,893	4,017	41,161	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	51,704	3,003	4,170	8,042	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,221,753	112,481	156,173	236,425	30.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,945	0	0	0	54.00
60.00 06000	LABORATORY	58,050	0	0	0	60.00
65.00 06500	RESPIRATORY THERAPY	101,815	1,155	1,604	18,747	65.00
66.00 06600	PHYSICAL THERAPY	358,276	18,291	25,396	64,741	66.00
67.00 06700	OCCUPATIONAL THERAPY	321,166	12,382	17,192	62,674	67.00
68.00 06800	SPEECH PATHOLOGY	112,542	1,271	1,764	21,825	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	135,849	2,657	3,689	4,336	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	377,245	3,234	4,491	48,745	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
93.00 04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS						
117.00 06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	7,111,262	266,915	370,599	746,376	118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	8,247	11,451	0	192.00
194.00 07950	MARKETING	0	474	658	0	194.00
194.01 07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.01
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	7,111,262	275,636	382,708	746,376	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet B
Part I
Date/Time Prepared:
5/20/2014 4:21 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	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,085,391				5.00
7.00	00700	OPERATION OF PLANT	189,330	645,622			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	10,350	0	35,295		8.00
9.00	00900	HOUSEKEEPING	102,235	6,003	0	354,628	9.00
10.00	01000	DIETARY	181,990	84,541	0	46,873	752,007
13.00	01300	NURSING ADMINISTRATION	109,118	9,670	0	5,361	0
16.00	01600	MEDICAL RECORDS & LIBRARY	27,767	10,037	0	5,565	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	716,517	375,920	35,295	208,423	752,007
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,222	0	0	0	0
60.00	06000	LABORATORY	24,087	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	51,170	3,860	0	2,140	0
66.00	06600	PHYSICAL THERAPY	193,650	61,128	0	33,892	0
67.00	06700	OCCUPATIONAL THERAPY	171,538	41,383	0	22,944	0
68.00	06800	SPEECH PATHOLOGY	57,012	4,246	0	2,354	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	60,800	8,879	0	4,923	0
73.00	07300	DRUGS CHARGED TO PATIENTS	179,962	10,809	0	5,993	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,076,748	616,476	35,295	338,468	752,007
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,173	27,563	0	15,282	0
194.00	07950	MARKETING	470	1,583	0	878	0
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	2,085,391	645,622	35,295	354,628	752,007

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet B
Part I
Date/Time Prepared:
5/20/2014 4:21 pm

Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		13.00	16.00	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
13.00	01300	387,127					13.00
16.00	01600	0	110,288				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	387,127	49,079	4,251,200	0	4,251,200	30.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	455	4,622	0	4,622	54.00
60.00	06000	0	4,094	86,231	0	86,231	60.00
65.00	06500	0	2,843	183,334	0	183,334	65.00
66.00	06600	0	15,423	770,797	0	770,797	66.00
67.00	06700	0	15,626	664,905	0	664,905	67.00
68.00	06800	0	4,942	205,956	0	205,956	68.00
71.00	07100	0	1,491	222,624	0	222,624	71.00
73.00	07300	0	16,335	646,814	0	646,814	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03950	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
93.00	04950	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
117.00	06950	0	0	0	0	0	117.00
118.00		387,127	110,288	7,036,483	0	7,036,483	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	70,716	0	70,716	192.00
194.00	07950	0	0	4,063	0	4,063	194.00
194.01	07951	0	0	0	0	0	194.01
200.00				0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		387,127	110,288	7,111,262	0	7,111,262	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 153042	Period: From 04/18/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 5/20/2014 4:21 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,109	1,540	2,649	2,649 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	17,956	24,931	42,887	582 5.00
7.00 00700	OPERATION OF PLANT	0	63,391	88,015	151,406	49 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0 8.00
9.00 00900	HOUSEKEEPING	0	1,796	2,494	4,290	90 9.00
10.00 01000	DIETARY	0	25,296	35,123	60,419	130 10.00
13.00 01300	NURSING ADMINISTRATION	0	2,893	4,017	6,910	146 13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	3,003	4,170	7,173	29 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	112,481	156,173	268,654	838 30.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
ANCILLARY SERVICE COST CENTERS						
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	1,155	1,604	2,759	67 65.00
66.00 06600	PHYSICAL THERAPY	0	18,291	25,396	43,687	230 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	12,382	17,192	29,574	223 67.00
68.00 06800	SPEECH PATHOLOGY	0	1,271	1,764	3,035	77 68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,657	3,689	6,346	15 71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	3,234	4,491	7,725	173 73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0 74.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0 76.00
OUTPATIENT SERVICE COST CENTERS						
93.00 04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0 93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
SPECIAL PURPOSE COST CENTERS						
117.00 06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0 117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	266,915	370,599	637,514	2,649 118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	8,247	11,451	19,698	0 192.00
194.00 07950	MARKETING	0	474	658	1,132	0 194.00
194.01 07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.01
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	0	275,636	382,708	658,344	2,649 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet B
Part II
Date/Time Prepared:
5/20/2014 4:21 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						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	43,469					5.00
7.00	00700	3,946	155,401				7.00
8.00	00800	216	0	216			8.00
9.00	00900	2,131	1,445	0	7,956		9.00
10.00	01000	3,793	20,349	0	1,052	85,743	10.00
13.00	01300	2,274	2,328	0	120	0	13.00
16.00	01600	579	2,416	0	125	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	14,937	90,483	216	4,676	85,743	30.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	25	0	0	0	0	54.00
60.00	06000	502	0	0	0	0	60.00
65.00	06500	1,067	929	0	48	0	65.00
66.00	06600	4,037	14,714	0	760	0	66.00
67.00	06700	3,576	9,961	0	515	0	67.00
68.00	06800	1,188	1,022	0	53	0	68.00
71.00	07100	1,267	2,137	0	110	0	71.00
73.00	07300	3,751	2,602	0	134	0	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03950	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
93.00	04950	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
117.00	06950	0	0	0	0	0	117.00
118.00		43,289	148,386	216	7,593	85,743	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	170	6,634	0	343	0	192.00
194.00	07950	10	381	0	20	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		43,469	155,401	216	7,956	85,743	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet B
Part II
Date/Time Prepared:
5/20/2014 4:21 pm

Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		13.00	16.00	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
13.00	01300	11,778					13.00
16.00	01600	0	10,322				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	11,778	4,591	481,916	0	481,916	30.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	43	68	0	68	54.00
60.00	06000	0	383	885	0	885	60.00
65.00	06500	0	266	5,136	0	5,136	65.00
66.00	06600	0	1,444	64,872	0	64,872	66.00
67.00	06700	0	1,463	45,312	0	45,312	67.00
68.00	06800	0	463	5,838	0	5,838	68.00
71.00	07100	0	140	10,015	0	10,015	71.00
73.00	07300	0	1,529	15,914	0	15,914	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03950	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
93.00	04950	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
117.00	06950	0	0	0	0	0	117.00
118.00		11,778	10,322	629,956	0	629,956	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	26,845	0	26,845	192.00
194.00	07950	0	0	1,543	0	1,543	194.00
194.01	07951	0	0	0	0	0	194.01
200.00				0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		11,778	10,322	658,344	0	658,344	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet B-1
Date/Time Prepared:
5/20/2014 4:21 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	47,726				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		47,726			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	192	192	3,500,992		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,109	3,109	768,777	-2,085,391	5.00
7.00 00700	OPERATION OF PLANT	10,976	10,976	64,919	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	311	311	118,676	0	9.00
10.00 01000	DIETARY	4,380	4,380	171,878	0	10.00
13.00 01300	NURSING ADMINISTRATION	501	501	193,071	0	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	520	520	37,721	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	19,476	19,476	1,108,998	0	30.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	0	0	0	0	60.00
65.00 06500	RESPIRATORY THERAPY	200	200	87,937	0	65.00
66.00 06600	PHYSICAL THERAPY	3,167	3,167	303,677	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	2,144	2,144	293,980	0	67.00
68.00 06800	SPEECH PATHOLOGY	220	220	102,373	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	460	460	20,340	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	560	560	228,645	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
93.00 04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS						
117.00 06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	46,216	46,216	3,500,992	-2,085,391	118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	1,428	1,428	0	0	192.00
194.00 07950	MARKETING	82	82	0	0	194.00
194.01 07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.01
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)	275,636	382,708	746,376	2,085,391	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	5.775384	8.018858	0.213190	0.414931	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			2,649	43,469	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000757	0.008649	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet B-1

Date/Time Prepared:
5/20/2014 4:21 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	NURSING ADMINISTRATION (NURSING SALARIES)	
		7.00	8.00	9.00	10.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	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	33,449				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,498			8.00
9.00	00900	HOUSEKEEPING	311	0	33,138		9.00
10.00	01000	DIETARY	4,380	0	4,380	4,498	10.00
13.00	01300	NURSING ADMINISTRATION	501	0	501	0	1,108,998
16.00	01600	MEDICAL RECORDS & LIBRARY	520	0	520	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	19,476	4,498	19,476	4,498	1,108,998
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
60.00	06000	LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	200	0	200	0	0
66.00	06600	PHYSICAL THERAPY	3,167	0	3,167	0	0
67.00	06700	OCCUPATIONAL THERAPY	2,144	0	2,144	0	0
68.00	06800	SPEECH PATHOLOGY	220	0	220	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	460	0	460	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	560	0	560	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	31,939	4,498	31,628	4,498	1,108,998
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,428	0	1,428	0	0
194.00	07950	MARKETING	82	0	82	0	0
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	645,622	35,295	354,628	752,007	387,127
203.00		Unit cost multiplier (Wkst. B, Part I)	19.301683	7.846821	10.701551	167.186972	0.349078
204.00		Cost to be allocated (per Wkst. B, Part II)	155,401	216	7,956	85,743	11,778
205.00		Unit cost multiplier (Wkst. B, Part II)	4.645909	0.048021	0.240087	19.062472	0.010620

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet B-1
Date/Time Prepared:
5/20/2014 4:21 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		16.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	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
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
		9,358,226	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
44.00	04400	SKILLED NURSING FACILITY	44.00
		4,164,300	
		0	
ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	76.00
		38,616	
		347,399	
		241,269	
		1,308,711	
		1,325,935	
		419,385	
		126,509	
		1,386,102	
		0	
		0	
OUTPATIENT SERVICE COST CENTERS			
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	93.00
		0	
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
		0	
SPECIAL PURPOSE COST CENTERS			
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
		9,358,226	
NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	MARKETING	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	194.01
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)	202.00
		110,288	
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
		0.011785	
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
		10,322	
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00
		0.001103	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet C
Part I
Date/Time Prepared:
5/20/2014 4:21 pm

		Title XVIII		Hospital		PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	4,251,200		4,251,200	0	4,251,200 30.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0 44.00
ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,622		4,622	0	4,622 54.00
60.00	06000 LABORATORY	86,231		86,231	0	86,231 60.00
65.00	06500 RESPIRATORY THERAPY	183,334	0	183,334	0	183,334 65.00
66.00	06600 PHYSICAL THERAPY	770,797	0	770,797	0	770,797 66.00
67.00	06700 OCCUPATIONAL THERAPY	664,905	0	664,905	0	664,905 67.00
68.00	06800 SPEECH PATHOLOGY	205,956	0	205,956	0	205,956 68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	222,624		222,624	0	222,624 71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	646,814		646,814	0	646,814 73.00
74.00	07400 RENAL DIALYSIS	0		0	0	0 74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0 76.00
OUTPATIENT SERVICE COST CENTERS						
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0 93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0		0	0	0 95.00
SPECIAL PURPOSE COST CENTERS						
117.00	06950 OTHER SPECIAL PURPOSE COST CENTERS	0		0	0	0 117.00
200.00	Subtotal (see instructions)	7,036,483	0	7,036,483	0	7,036,483 200.00
201.00	Less Observation Beds	0		0	0	0 201.00
202.00	Total (see instructions)	7,036,483	0	7,036,483	0	7,036,483 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 153042		Period: From 04/18/2013 To 12/31/2013		Worksheet C Part I Date/Time Prepared: 5/20/2014 4:21 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,164,300		4,164,300			30.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,616	0	38,616	0.119691	0.000000	54.00
60.00	06000	LABORATORY	347,399	0	347,399	0.248219	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	241,269	0	241,269	0.759874	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,272,050	36,661	1,308,711	0.588974	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,308,320	17,615	1,325,935	0.501461	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	407,945	11,440	419,385	0.491091	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	126,509	0	126,509	1.759748	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,386,102	0	1,386,102	0.466642	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
SPECIAL PURPOSE COST CENTERS								
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0			117.00
200.00		Subtotal (see instructions)	9,292,510	65,716	9,358,226			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,292,510	65,716	9,358,226			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 153042	Period: From 04/18/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/20/2014 4:21 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
44.00	04400 SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.119691		54.00
60.00	06000 LABORATORY	0.248219		60.00
65.00	06500 RESPIRATORY THERAPY	0.759874		65.00
66.00	06600 PHYSICAL THERAPY	0.588974		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.501461		67.00
68.00	06800 SPEECH PATHOLOGY	0.491091		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.759748		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.466642		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS				
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
SPECIAL PURPOSE COST CENTERS				
117.00	06950 OTHER SPECIAL PURPOSE COST CENTERS			117.00
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: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet C
Part I
Date/Time Prepared:
5/20/2014 4:21 pm

		Title XIX		Hospital		PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	4,251,200		4,251,200	0	4,251,200 30.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0 44.00
ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,622		4,622	0	4,622 54.00
60.00	06000 LABORATORY	86,231		86,231	0	86,231 60.00
65.00	06500 RESPIRATORY THERAPY	183,334	0	183,334	0	183,334 65.00
66.00	06600 PHYSICAL THERAPY	770,797	0	770,797	0	770,797 66.00
67.00	06700 OCCUPATIONAL THERAPY	664,905	0	664,905	0	664,905 67.00
68.00	06800 SPEECH PATHOLOGY	205,956	0	205,956	0	205,956 68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	222,624		222,624	0	222,624 71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	646,814		646,814	0	646,814 73.00
74.00	07400 RENAL DIALYSIS	0		0	0	0 74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0 76.00
OUTPATIENT SERVICE COST CENTERS						
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0 93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0		0	0	0 95.00
SPECIAL PURPOSE COST CENTERS						
117.00	06950 OTHER SPECIAL PURPOSE COST CENTERS	0		0	0	0 117.00
200.00	Subtotal (see instructions)	7,036,483	0	7,036,483	0	7,036,483 200.00
201.00	Less Observation Beds	0		0	0	0 201.00
202.00	Total (see instructions)	7,036,483	0	7,036,483	0	7,036,483 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 153042	Period: From 04/18/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/20/2014 4:21 pm
	Title XIX	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	4,164,300		4,164,300			30.00
44.00 04400 SKILLED NURSING FACILITY	0		0			44.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400 RADIOLOGY-DIAGNOSTIC	38,616	0	38,616	0.119691	0.000000	54.00
60.00 06000 LABORATORY	347,399	0	347,399	0.248219	0.000000	60.00
65.00 06500 RESPIRATORY THERAPY	241,269	0	241,269	0.759874	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	1,272,050	36,661	1,308,711	0.588974	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	1,308,320	17,615	1,325,935	0.501461	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	407,945	11,440	419,385	0.491091	0.000000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	126,509	0	126,509	1.759748	0.000000	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,386,102	0	1,386,102	0.466642	0.000000	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS						
93.00 04950 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
SPECIAL PURPOSE COST CENTERS						
117.00 06950 OTHER SPECIAL PURPOSE COST CENTERS	0	0	0			117.00
200.00 Subtotal (see instructions)	9,292,510	65,716	9,358,226			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	9,292,510	65,716	9,358,226			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 153042	Period: From 04/18/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/20/2014 4:21 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital PPS
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
44.00	04400 SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.119691		54.00
60.00	06000 LABORATORY	0.248219		60.00
65.00	06500 RESPIRATORY THERAPY	0.759874		65.00
66.00	06600 PHYSICAL THERAPY	0.588974		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.501461		67.00
68.00	06800 SPEECH PATHOLOGY	0.491091		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.759748		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.466642		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS				
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
SPECIAL PURPOSE COST CENTERS				
117.00	06950 OTHER SPECIAL PURPOSE COST CENTERS			117.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

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

Provider CCN: 153042

Period: From 04/18/2013 To 12/31/2013

Worksheet C Part II Date/Time Prepared: 5/20/2014 4:21 pm

Cost Center Description		Title XIX			Hospital		PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,622	68	4,554	0	0	54.00
60.00	06000	LABORATORY	86,231	885	85,346	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	183,334	5,136	178,198	0	0	65.00
66.00	06600	PHYSICAL THERAPY	770,797	64,872	705,925	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	664,905	45,312	619,593	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	205,956	5,838	200,118	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	222,624	10,015	212,609	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	646,814	15,914	630,900	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
200.00		Subtotal (sum of lines 50 thru 199)	2,785,283	148,040	2,637,243	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	2,785,283	148,040	2,637,243	0	0	202.00

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

Provider CCN: 153042

Period: From 04/18/2013 To 12/31/2013

Worksheet C Part II Date/Time Prepared: 5/20/2014 4:21 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
		6.00	7.00	8.00		
Title XIX Hospital PPS						
ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,622	38,616	0.119691	54.00
60.00	06000	LABORATORY	86,231	347,399	0.248219	60.00
65.00	06500	RESPIRATORY THERAPY	183,334	241,269	0.759874	65.00
66.00	06600	PHYSICAL THERAPY	770,797	1,308,711	0.588974	66.00
67.00	06700	OCCUPATIONAL THERAPY	664,905	1,325,935	0.501461	67.00
68.00	06800	SPEECH PATHOLOGY	205,956	419,385	0.491091	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	222,624	126,509	1.759748	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	646,814	1,386,102	0.466642	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS						
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	95.00
SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0.000000	117.00
200.00		Subtotal (sum of lines 50 thru 199)	2,785,283	5,193,926		200.00
201.00		Less Observation Beds	0	0		201.00
202.00		Total (line 200 minus line 201)	2,785,283	5,193,926		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 153042		Period: From 04/18/2013 To 12/31/2013		Worksheet D Part I Date/Time Prepared: 5/20/2014 4:21 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	481,916	0	481,916	4,498	107.14	30.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (Lines 30-199)	481,916		481,916	4,498		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	2,947	315,742				
44.00	SKILLED NURSING FACILITY	0	0				
200.00	Total (Lines 30-199)	2,947	315,742				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 153042	Period: From 04/18/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/20/2014 4:21 pm			
Title XVIII			Hospital		PPS			
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	68	38,616	0.001761	24,274	43	54.00
60.00	06000	LABORATORY	885	347,399	0.002548	227,830	581	60.00
65.00	06500	RESPIRATORY THERAPY	5,136	241,269	0.021287	171,464	3,650	65.00
66.00	06600	PHYSICAL THERAPY	64,872	1,308,711	0.049569	830,830	41,183	66.00
67.00	06700	OCCUPATIONAL THERAPY	45,312	1,325,935	0.034174	852,475	29,132	67.00
68.00	06800	SPEECH PATHOLOGY	5,838	419,385	0.013920	186,755	2,600	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,015	126,509	0.079164	67,884	5,374	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,914	1,386,102	0.011481	918,752	10,548	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	148,040	5,193,926		3,280,264	93,111	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 153042		Period: From 04/18/2013 To 12/31/2013		Worksheet D Part III Date/Time Prepared: 5/20/2014 4:21 pm	
Cost Center Description			Title XVIII		Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,498	0.00	2,947	0		30.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0		44.00
200.00		Total (lines 30-199)	4,498		2,947	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet D
Part IV
Date/Time Prepared:
5/20/2014 4:21 pm

Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS									
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 153042	Period: From 04/18/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/20/2014 4:21 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	38,616	0.000000	0.000000	24,274	54.00
60.00	06000	LABORATORY	0	347,399	0.000000	0.000000	227,830	60.00
65.00	06500	RESPIRATORY THERAPY	0	241,269	0.000000	0.000000	171,464	65.00
66.00	06600	PHYSICAL THERAPY	0	1,308,711	0.000000	0.000000	830,830	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,325,935	0.000000	0.000000	852,475	67.00
68.00	06800	SPEECH PATHOLOGY	0	419,385	0.000000	0.000000	186,755	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	126,509	0.000000	0.000000	67,884	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,386,102	0.000000	0.000000	918,752	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS								
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	5,193,926			3,280,264	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet D
Part IV
Date/Time Prepared:
5/20/2014 4:21 pm

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
Title XVIII Hospital PPS						
ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 153042		Period: From 04/18/2013 To 12/31/2013		Worksheet D Part I Date/Time Prepared: 5/20/2014 4:21 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4) PPS	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	481,916	0	481,916	4,498	107.14	30.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (Lines 30-199)	481,916		481,916	4,498		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	325	34,821				
44.00	SKILLED NURSING FACILITY	0	0				
200.00	Total (Lines 30-199)	325	34,821				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 153042	Period: From 04/18/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/20/2014 4:21 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	68	38,616	0.001761	0	54.00
60.00	06000	LABORATORY	885	347,399	0.002548	0	60.00
65.00	06500	RESPIRATORY THERAPY	5,136	241,269	0.021287	0	65.00
66.00	06600	PHYSICAL THERAPY	64,872	1,308,711	0.049569	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	45,312	1,325,935	0.034174	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,838	419,385	0.013920	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,015	126,509	0.079164	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,914	1,386,102	0.011481	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS							
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	148,040	5,193,926		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 153042		Period: From 04/18/2013 To 12/31/2013		Worksheet D Part III Date/Time Prepared: 5/20/2014 4:21 pm	
Cost Center Description			Title XIX		Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,498	0.00	325	0		30.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0		44.00
200.00		Total (lines 30-199)	4,498		325	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet D
Part IV
Date/Time Prepared:
5/20/2014 4:21 pm

Cost Center Description		Title XIX			Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet D
Part IV
Date/Time Prepared:
5/20/2014 4:21 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	PPS
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)			
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	38,616	0.000000	0.000000	0	54.00
60.00	06000	LABORATORY	0	347,399	0.000000	0.000000	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	241,269	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,308,711	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,325,935	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	419,385	0.000000	0.000000	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	126,509	0.000000	0.000000	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,386,102	0.000000	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS								
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	5,193,926			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet D
Part IV
Date/Time Prepared:
5/20/2014 4:21 pm

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 153042	Period: From 04/18/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/20/2014 4:21 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,498	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,498	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,498	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,947	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	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)		4,251,200	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,251,200	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)		4,251,200	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)		945.13	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,785,298	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,785,298	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 153042	Period: From 04/18/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/20/2014 4:21 pm
Title XVIII			Hospital		PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,746,469 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,531,767 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)					315,742 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					93,111 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					408,853 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,122,914 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 153042		Period: From 04/18/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/20/2014 4:21 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	481,916	4,251,200	0.113360	0	0	90.00
91.00	Nursing School cost	0	4,251,200	0.000000	0	0	91.00
92.00	Allied health cost	0	4,251,200	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,251,200	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 153042	Period: From 04/18/2013 To 12/31/2013	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/20/2014 4:21 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,498	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,498	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,498	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		325	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	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)		4,251,200	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,251,200	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)		4,251,200	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)		945.13	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		307,167	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)		307,167	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 153042	Period: From 04/18/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/20/2014 4:21 pm
Cost Center Description			Title XIX	Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
Cost Center Description					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				0 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				307,167 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)				34,821 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)				34,821 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				272,346 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				0 54.00
55.00	Target amount per discharge				0.00 55.00
56.00	Target amount (line 54 x line 55)				0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0 57.00
58.00	Bonus payment (see instructions)				0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0 61.00
62.00	Relief payment (see instructions)				0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)				70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				71.00
72.00	Program routine service cost (line 9 x line 71)				72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				76.00
77.00	Program capital-related costs (line 9 x line 76)				77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				80.00
81.00	Inpatient routine service cost per diem limitation				81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				82.00
83.00	Reasonable inpatient routine service costs (see instructions)				83.00
84.00	Program inpatient ancillary services (see instructions)				84.00
85.00	Utilization review - physician compensation (see instructions)				85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)				0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 153042		Period: From 04/18/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/20/2014 4:21 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	481,916	4,251,200	0.113360	0	0	90.00
91.00	Nursing School cost	0	4,251,200	0.000000	0	0	91.00
92.00	Allied health cost	0	4,251,200	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,251,200	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 153042	Period: From 04/18/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/20/2014 4:21 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		2,652,300		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.119691	24,274	2,905	54.00
60.00	06000 LABORATORY	0.248219	227,830	56,552	60.00
65.00	06500 RESPIRATORY THERAPY	0.759874	171,464	130,291	65.00
66.00	06600 PHYSICAL THERAPY	0.588974	830,830	489,337	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.501461	852,475	427,483	67.00
68.00	06800 SPEECH PATHOLOGY	0.491091	186,755	91,714	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.759748	67,884	119,459	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.466642	918,752	428,728	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		3,280,264	1,746,469	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)		3,280,264		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 153042	Period: From 04/18/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/20/2014 4:21 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS			0	30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.119691		0	54.00
60.00	06000 LABORATORY	0.248219		0	60.00
65.00	06500 RESPIRATORY THERAPY	0.759874		0	65.00
66.00	06600 PHYSICAL THERAPY	0.588974		0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.501461		0	67.00
68.00	06800 SPEECH PATHOLOGY	0.491091		0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.759748		0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.466642		0	73.00
74.00	07400 RENAL DIALYSIS	0.000000		0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000		0	76.00
OUTPATIENT SERVICE COST CENTERS					
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0.000000		0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)			0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)			0	201.00
202.00	Net Charges (line 200 minus line 201)			0	202.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet E-1
Part I
Date/Time Prepared:
5/20/2014 4:21 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		3,426,816		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)		3,426,816		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		101,578		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		3,528,394		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		Provider CCN: 153042	Period: From 04/18/2013 To 12/31/2013	Worksheet E-3 Part III Date/Time Prepared: 5/20/2014 4:21 pm
		Title XVIII	Hospital	PPS
		Prior to 10/01	On/After 10/01	
		1.00	1.01	
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)	1,893,398	1,685,641	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0000		2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	64,376	39,275	3.00
4.00	Outlier Payments	0		4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00		5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00		5.01
6.00	New Teaching program adjustment. (see instructions)	0.00		6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program". (see inst.)	0.00		7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program". (see inst.)	0.00		8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00		9.00
10.00	Average Daily Census (see instructions)	17.434109		10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	0	12.00
13.00	Total PPS Payment (see instructions)	3,682,690		13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0		14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			15.00
16.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0		16.00
17.00	Subtotal (see instructions)	3,682,690		17.00
18.00	Primary payer payments	0		18.00
19.00	Subtotal (line 17 less line 18).	3,682,690		19.00
20.00	Deductibles	46,176		20.00
21.00	Subtotal (line 19 minus line 20)	3,636,514		21.00
22.00	Coinsurance	36,112		22.00
23.00	Subtotal (line 21 minus line 22)	3,600,402		23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0		24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0		25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		26.00
27.00	Subtotal (sum of lines 23 and 25)	3,600,402		27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0		28.00
29.00	Other pass through costs (see instructions)	0		29.00
30.00	Outlier payments reconciliation	0		30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		31.00
31.99	Recovery of Accelerated Depreciation	0		31.99
32.00	Total amount payable to the provider (see instructions)	3,600,402		32.00
32.01	Sequestration adjustment (see instructions)	72,008		32.01
33.00	Interim payments	3,426,816		33.00
34.00	Tentative settlement (for contractor use only)	0		34.00
35.00	Balance due provider/program line 32 minus lines 32.01, 33 and 34	101,578		35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0		36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4	0		50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0		51.00
52.00	The rate used to calculate the Time Value of Money	0.00		52.00
53.00	Time Value of Money (see instructions)	0		53.00

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

Provider CCN: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet G

Date/Time Prepared:
5/20/2014 4:21 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	31,436	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,707,069	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,725,448	0	0	0	6.00
7.00	Inventory	76,936	0	0	0	7.00
8.00	Prepaid expenses	21,287	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	3,111,280	0	0	0	11.00
FIXED ASSETS						
12.00	Land	800,183	0	0	0	12.00
13.00	Land improvements	41,998	0	0	0	13.00
14.00	Accumulated depreciation	-3,376	0	0	0	14.00
15.00	Buildings	11,214,379	0	0	0	15.00
16.00	Accumulated depreciation	-254,524	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	62,244	0	0	0	21.00
22.00	Accumulated depreciation	-12,106	0	0	0	22.00
23.00	Major movable equipment	2,670,576	0	0	0	23.00
24.00	Accumulated depreciation	-342,622	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)	14,176,752	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	21,021,953	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	21,021,953	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	38,309,985	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	92,937	0	0	0	37.00
38.00	Salaries, wages, and fees payable	137,269	0	0	0	38.00
39.00	Payroll taxes payable	94,796	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	23,728,859	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	24,053,861	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	16,095,394	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	171,333	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	16,266,727	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	40,320,588	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-2,010,603				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)	-2,010,603	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	38,309,985	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet G-1

Date/Time Prepared:
5/20/2014 4:21 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		0		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-3,084,630			2.00
3.00	Total (sum of line 1 and line 2)		-3,084,630		0	3.00
4.00	INTERCOMPANY ADJ	1,074,027		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		1,074,027		0	10.00
11.00	Subtotal (line 3 plus line 10)		-2,010,603		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-2,010,603		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	INTERCOMPANY ADJ		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/20/2014 4:21 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	4,164,300		4,164,300	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	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,164,300		4,164,300	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,164,300		4,164,300	17.00
18.00	Ancillary services	5,128,210	65,716	5,193,926	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	0	0	0	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)	9,292,510	65,716	9,358,226	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		8,101,298		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		8,101,298		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 153042

Period:
From 04/18/2013
To 12/31/2013

Worksheet G-3

Date/Time Prepared:
5/20/2014 4:21 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	9,358,226	1.00
2.00	Less contractual allowances and discounts on patients' accounts	4,369,658	2.00
3.00	Net patient revenues (line 1 minus line 2)	4,988,568	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	8,101,298	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,112,730	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	2,114	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	20,036	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	157	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC INC, TRANSPORT	5,793	24.00
25.00	Total other income (sum of lines 6-24)	28,100	25.00
26.00	Total (line 5 plus line 25)	-3,084,630	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)	-3,084,630	29.00