

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151304	Period: From 01/01/2013 To 12/31/2013	Worksheet 5 Parts I-III Date/Time Prepared: 5/30/2014 2:54 pm
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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.

Date: 5/30/2014 Time: 2:54 pm

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.

PART II - CERTIFICATION

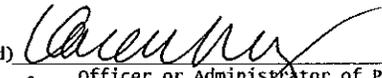
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR 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 RUSH MEMORIAL HOSPITAL (151304) for the cost reporting period beginning 01/01/2013 and ending 12/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 5/30/2014 Time: 2:54 pm
 bfKBawxZurEIXmTGY9QsL0C.TIrt0
 F3IS80Z.eJtCFcntQ8lIg0QZDexdG5
 bqkx0Sa59I0v3kqf
 PI: Date: 5/30/2014 Time: 2:54 pm
 ssqBONo5D1ZgJvpUw028BXR1DKB1g0
 wU8:B0s4gLiG2mVTDp0MBw00ek:kog
 q4U503HaTd0XIIcN

(Signed) 
 Officer or Administrator of Provider(s)
 VP of Finance & CFO
 Title
 5/31/14
 Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	58,963	198,380	0	-20,667	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	64,746	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
200.00 Total	0	123,709	198,380	0	-20,667	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: 151304		Period: From 01/01/2013 To 12/31/2013		Worksheet S-2 Part I Date/Time Prepared: 5/30/2014 2:52 pm					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1300 NORTH MAIN STREET		PO Box:					1.00			
2.00	City: RUSHVILLE		State: IN		Zip Code: 46173-		County: RUSH				
		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		RUSH MEMORIAL HOSPITAL	151304	99915	1	08/01/2000	N	0	0	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		RUSH SWING BEDS	152304	99915		08/01/2000	N	0	N	7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
						From:	To:				
						1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2013	12/31/2013		20.00		
21.00	Type of Control (see instructions)					2		21.00			
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					N		22.00			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)							22.01			
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					0		23.00			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.					0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.					0	0	0	0	0	25.00
						Urban/Rural	S	Date of Geogr			
						1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00			
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00			
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00			

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		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)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
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		
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)			0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)			0.00	62.01	
<u>Teaching Hospitals that Claim Residents in Non-Provider Settings</u>						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)			N	63.00	
			Unweighted FTEs 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	
<u>Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010</u>						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00

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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
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.			N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	76.00
					1.00		
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N	80.00
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00
				V	XIX		
				1.00	2.00		
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	97.00
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			N			106.00

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		V	XIX		
		1.00	2.00		
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	Y	Y	N
		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		
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	211,625	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		
119.00	DO NOT USE THIS LINE				
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N		N
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		
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		
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.				
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.				
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.				
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.				
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.				
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.				
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.				
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.				
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.				
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		N		

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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:	Contractor's Name:		Contractor's Number:		141.00								
142.00	Street:	PO Box:				142.00								
143.00	City:	State:		Zip Code:		143.00								
						1.00								
144.00	Are provider based physicians' costs included in Worksheet A?						Y 144.00							
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.						N 145.00							
						1.00								
						2.00								
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						N 146.00							
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N 147.00							
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N 148.00							
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N 149.00							
		Part A		Part B		Title V		Title XIX						
		1.00		2.00		3.00		4.00						
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)														
155.00	Hospital	N		N		N		N 155.00						
156.00	Subprovider - IPF	N		N		N		N 156.00						
157.00	Subprovider - IRF	N		N		N		N 157.00						
158.00	SUBPROVIDER							158.00						
159.00	SNF	N		N		N		N 159.00						
160.00	HOME HEALTH AGENCY	N		N		N		N 160.00						
161.00	CMHC			N		N		N 161.00						
						1.00								
Multi campus														
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N		165.00					
		Name		County		State		Zip Code		CBSA		FTE/Campus		
		0		1.00		2.00		3.00		4.00		5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5										0.00		166.00	
						1.00								
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act														
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						Y		167.00					
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								0 168.00					
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								0.00 169.00					
						Beginning		Ending						
						1.00		2.00						
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)						10/01/2012		09/30/2013		170.00			

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151304	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/30/2014 2:52 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			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.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	03/06/2014	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

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MI CHAEL		ALESSANDRI NI	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-633-4705		MALESSANDRI NI@BLUEANDCO.COM	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	03/06/2014	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.	CONSULTANT	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: 151304

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2014 2:52 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	25	9,125	33,408.00	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)		25	9,125	33,408.00	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)		25	9,125	33,408.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151304

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2014 2:52 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,015	65	1,392			1.00
2.00 HMO and other (see instructions)	45	5				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	513	0	523			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	108			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,528	65	2,023			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)	1,528	65	2,023	0.00	0.00	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	0.00	27.00
28.00 Observation Bed Days		45	316			28.00
29.00 Ambulance Trips	9,044					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: 151304

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2014 2:52 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	303	22	451	1.00
2.00 HMO and other (see instructions)				15			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	303	22	451		14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151304	Period: From 01/01/2013 To 12/31/2013	Worksheet S-10 Date/Time Prepared: 5/30/2014 2:52 pm
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.411757	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		1,936,925	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		Y	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		6,883,996	6.00	
7.00	Medicaid cost (line 1 times line 6)		2,834,534	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		897,609	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		348,476	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		897,609	19.00	
			Uninsured patients	Insured patients	
			1.00	2.00	
			Total (col. 1 + col. 2)		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	786,985	0	786,985	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	324,047	0	324,047	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	324,047	0	324,047	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		3,588,587	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		324,840	27.00	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		3,263,747	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,343,871	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,667,918	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,565,527	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151304

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

Worksheet A
Date/Time Prepared:
5/30/2014 2:52 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	NEW CAP REL COSTS-BLDG & FIXT		1,610,220		1,610,220	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	295,072	2,232,243		2,527,315	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,986,982	1,540,014		3,526,996	5.00
7.00	00700	OPERATION OF PLANT	187,644	499,163		686,807	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0		0	8.00
9.00	00900	HOUSEKEEPING	242,603	132,087		374,690	9.00
10.00	01000	DIETARY	317,889	253,180		571,069	10.00
11.00	01100	CAFETERIA	0	0		0	11.00
13.00	01300	NURSING ADMINISTRATION	113,558	1,740		115,298	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	47,998	180,182		228,180	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	241,476	124,982		366,458	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	823,510	58,575		882,085	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	422,805	380,866		803,671	50.00
51.00	05100	RECOVERY ROOM	0	1,697		1,697	51.00
53.00	05300	ANESTHESIOLOGY	0	0		0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	788,592	968,444		1,757,036	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		0	55.00
60.00	06000	LABORATORY	559,716	776,506		1,336,222	60.00
65.00	06500	RESPIRATORY THERAPY	92,790	5,749		98,539	65.00
66.00	06600	PHYSICAL THERAPY	289,675	96,765		386,440	66.00
67.00	06700	OCCUPATIONAL THERAPY	205,562	222		205,784	67.00
68.00	06800	SPEECH PATHOLOGY	3,522	0		3,522	68.00
69.00	06900	ELECTROCARDIOLOGY	172,769	2,729		175,498	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,630		14,630	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	95,854		95,854	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	368,404	1,713,833		2,082,237	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,111,976	611,888		3,723,864	90.00
91.00	09100	EMERGENCY	725,442	985,041		1,710,483	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				1,236	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	572,393	71,496		643,889	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,570,378	12,358,106		23,928,484	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		0	192.00
193.00	19300	NONPAID WORKERS	0	0		0	193.00
193.01	19301	FOUNDATION	46,470	37		46,507	193.01
193.02	19302	OCCUPATIONAL MEDICINE	25,000	2,427		27,427	193.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0		0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	11,641,848	12,360,570		24,002,418	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151304

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

Worksheet A
Date/Time Prepared:
5/30/2014 2:52 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-65,237	1,544,983	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-225	2,527,090	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-912,531	2,614,465	5.00
7.00	00700	OPERATION OF PLANT	-557	687,572	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	58,333	8.00
9.00	00900	HOUSEKEEPING	-389	315,968	9.00
10.00	01000	DIETARY	-2,982	150,923	10.00
11.00	01100	CAFETERIA	-187,577	229,587	11.00
13.00	01300	NURSING ADMINISTRATION	-1,145	114,153	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-13	108,720	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,772	360,686	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-548	881,646	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-371,137	398,201	50.00
51.00	05100	RECOVERY ROOM	0	36,030	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-580,039	1,176,997	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00	06000	LABORATORY	-1,125	1,335,097	60.00
65.00	06500	RESPIRATORY THERAPY	0	98,539	65.00
66.00	06600	PHYSICAL THERAPY	-29,610	356,830	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	205,784	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,522	68.00
69.00	06900	ELECTROCARDIOLOGY	-7	175,491	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-3,216	130,861	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	95,854	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-4,193	2,078,044	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-2,055,434	1,668,430	90.00
91.00	09100	EMERGENCY	-219	1,711,500	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	641,222	95.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,221,956	19,706,528	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	FOUNDATION	0	46,507	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	27,427	193.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	-4,221,956	19,780,462	200.00

RECLASSIFICATIONS

Provider CCN: 151304

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

Worksheet A-6

Date/Time Prepared:
5/30/2014 2:52 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - LAUNDRY AND LINEN					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	58,333	1.00
	TOTALS		0	58,333	
B - DIETARY/ CAFETERIA					
1.00	CAFETERIA	11.00	232,217	184,947	1.00
	TOTALS		232,217	184,947	
C - MED SUPPLY RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	119,447	1.00
	TOTALS		0	119,447	
D - AMBULANCE RECLASS					
1.00	OPERATION OF PLANT	7.00	1,322	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	109	0	2.00
3.00	EMERGENCY	91.00	1,236	0	3.00
	TOTALS		2,667	0	
E - SALARY RECLASS					
1.00	RECOVERY ROOM	51.00	34,333	0	1.00
	TOTALS		34,333	0	
500.00	Grand Total: Increases		269,217	362,727	500.00

Provider CCN: 151304

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

Worksheet A-6
Date/Time Prepared:
5/30/2014 2:52 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - LAUNDRY AND LINEN						
1.00	HOUSEKEEPING	9.00	0	58,333	0	1.00
	TOTALS		0	58,333		
B - DIETARY/ CAFETERIA						
1.00	DIETARY	10.00	232,217	184,947	0	1.00
	TOTALS		232,217	184,947		
C - MED SUPPLY RECLASS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	119,447	0	1.00
	TOTALS		0	119,447		
D - AMBULANCE RECLASS						
1.00	AMBULANCE SERVICES	95.00	2,667	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		2,667	0		
E - SALARY RECLASS						
1.00	OPERATING ROOM	50.00	34,333	0	0	1.00
	TOTALS		34,333	0		
500.00	Grand Total: Decreases		269,217	362,727		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151304

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

Worksheet A-7
Part I
Date/Time Prepared:
5/30/2014 2:52 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	164,978	23,730	0	23,730	0	1.00
2.00	Land Improvements	287,458	30,976	0	30,976	0	2.00
3.00	Buildings and Fixtures	12,476,518	1,113,970	0	1,113,970	0	3.00
4.00	Building Improvements	401,276	549,595	0	549,595	0	4.00
5.00	Fixed Equipment	808,202	5,500	0	5,500	0	5.00
6.00	Movable Equipment	10,383,279	584,135	0	584,135	67,075	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,521,711	2,307,906	0	2,307,906	67,075	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	24,521,711	2,307,906	0	2,307,906	67,075	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	188,708	0				1.00
2.00	Land Improvements	318,434	0				2.00
3.00	Buildings and Fixtures	13,590,488	0				3.00
4.00	Building Improvements	950,871	0				4.00
5.00	Fixed Equipment	813,702	0				5.00
6.00	Movable Equipment	10,900,339	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	26,762,542	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	26,762,542	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151304

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

Worksheet A-7
Part II
Date/Time Prepared:
5/30/2014 2:52 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,154,998	0	204,323	250,899	0	1.00
3.00	Total (sum of lines 1-2)	1,154,998	0	204,323	250,899	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,610,220				1.00
3.00	Total (sum of lines 1-2)	0	1,610,220				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151304

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

Worksheet A-7
Part III
Date/Time Prepared:
5/30/2014 2:52 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
		1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS								
1.00	NEW CAP REL COSTS-BLDG & FIXT	26,762,542	0	26,762,542	1.000000	0	1.00	
3.00	Total (sum of lines 1-2)	26,762,542	0	26,762,542	1.000000	0	3.00	
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
		6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS								
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,132,701	0	1.00	
3.00	Total (sum of lines 1-2)	0	0	0	1,132,701	0	3.00	
Cost Center Description		SUMMARY OF CAPITAL						
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
		11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS								
1.00	NEW CAP REL COSTS-BLDG & FIXT	161,383	250,899	0	0	1,544,983	1.00	
3.00	Total (sum of lines 1-2)	161,383	250,899	0	0	1,544,983	3.00	

ADJUSTMENTS TO EXPENSES

Provider CCN: 151304

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

Worksheet A-8

Date/Time Prepared:
5/30/2014 2:52 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	*** Cost Center Deleted ***	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)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-3,003,851	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		0			0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests			0		0.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts			0		0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	*** Cost Center Deleted ***	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-21,255	0	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00 CAFETERIA	B	-91,312	0	CAFETERIA	11.00	0	33.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
34.00 JAIL MEALS	B	-96,265	CAFETERIA		11.00	0 34.00
35.00 VENDING MACHINES	B	-893	ADMINISTRATIVE & GENERAL		5.00	0 35.00
37.00 SALE OF SUPPLIES	B	-3,216	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00	0 37.00
38.00 PHYSICIAN APPLICATION FEES	B	-11,400	ADMINISTRATIVE & GENERAL		5.00	0 38.00
39.00 NSF FEES	B	-225	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 39.00
40.00 MEDICAL RECORDS TRANSCRIPTION FEES	B	-5,772	MEDICAL RECORDS & LIBRARY		16.00	0 40.00
41.00 COPIER FEES	B	-17,289	ADMINISTRATIVE & GENERAL		5.00	0 41.00
42.00 ATHLETIC TRAINER - SCHOOL REV	B	-16,000	ADMINISTRATIVE & GENERAL		5.00	0 42.00
45.00 SALE OF SCRAP	B	-13	CENTRAL SERVICES & SUPPLY		14.00	0 45.00
45.02 MISC. INCOME	B	-1,105	ADMINISTRATIVE & GENERAL		5.00	0 45.02
45.03 MISC. INCOME	B	-65	DIETARY		10.00	0 45.03
45.04 MISC. INCOME	B	-594	RADIOLOGY-DIAGNOSTIC		54.00	0 45.04
45.05 INTEREST INCOME	B	-42,940	NEW CAP REL COSTS-BLDG & FIXT		1.00	11 45.05
45.06 TELEPHONE SALARY	A	-3,985	ADMINISTRATIVE & GENERAL		5.00	0 45.06
45.07 TELEPHONE OTHER	A	-900	ADMINISTRATIVE & GENERAL		5.00	0 45.07
45.08 TELEPHONE BENEFITS	A	-632	ADMINISTRATIVE & GENERAL		5.00	0 45.08
45.09 ADVERTISING	A	-176,274	ADMINISTRATIVE & GENERAL		5.00	0 45.09
45.10 IHA & AHA LOBBYING	A	-3,182	ADMINISTRATIVE & GENERAL		5.00	0 45.10
45.11 REBATES	B	-1,042	NEW CAP REL COSTS-BLDG & FIXT		1.00	9 45.11
45.12 REBATES	B	-5,606	ADMINISTRATIVE & GENERAL		5.00	0 45.12
45.13 REBATES	B	-557	OPERATION OF PLANT		7.00	0 45.13
45.14 REBATES	B	-389	HOUSEKEEPING		9.00	0 45.14
45.15 REBATES	B	-2,917	DIETARY		10.00	0 45.15
45.16 REBATES	B	-1,145	NURSING ADMINISTRATION		13.00	0 45.16
45.17 REBATES	B	-548	ADULTS & PEDIATRICS		30.00	0 45.17
45.18 REBATES	B	-771	OPERATING ROOM		50.00	0 45.18
45.19 REBATES	B	-1,394	RADIOLOGY-DIAGNOSTIC		54.00	0 45.19
45.20 REBATES	B	-1,125	LABORATORY		60.00	0 45.20
45.21 REBATES	B	-7	ELECTROCARDIOLOGY		69.00	0 45.21
45.23 REBATES	B	-4,193	DRUGS CHARGED TO PATIENTS		73.00	0 45.23
45.25 REBATES	B	-219	EMERGENCY		91.00	0 45.25
45.26 HAF EXPENSE	A	-583,741	ADMINISTRATIVE & GENERAL		5.00	0 45.26
45.27 SPONSORSHIPS	A	-5,738	ADMINISTRATIVE & GENERAL		5.00	0 45.27
45.28 PHYSICIAN RECRUITMENTS	A	-85,786	ADMINISTRATIVE & GENERAL		5.00	0 45.28
45.29 MASSAGE REVENUE	B	-29,610	PHYSICAL THERAPY		66.00	0 45.29
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,221,956				50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151304

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

Worksheet A-8-2

Date/Time Prepared:
5/30/2014 2:52 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	375,383	370,366	5,017	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	603,051	578,051	25,000	0	0	2.00
3.00	60.00	LABORATORY	36,000	0	36,000	0	0	3.00
4.00	90.00	CLINIC	2,475,349	2,055,434	419,914	0	0	4.00
5.00	91.00	EMERGENCY	921,701	0	921,701	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,411,484	3,003,851	1,407,632			200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	90.00	CLINIC	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	50.00	OPERATING ROOM	0	0	0	370,366	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	578,051	2.00
3.00	60.00	LABORATORY	0	0	0	0	3.00
4.00	90.00	CLINIC	0	0	0	2,055,434	4.00
5.00	91.00	EMERGENCY	0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	3,003,851	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151304		Period: From 01/01/2013 To 12/31/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/30/2014 2:52 pm	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					3	1.00
2.00	Line 1 multiplied by 15 hours per week					45	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					4	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	34.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	72.01	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.01	36.01	0.00			11.00
12.00	Number of travel hours (provider site)	0	7	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	330	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					2,484	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					2,484	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					2,484	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					72.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					3,240	22.00
23.00	Total salary equivalency (see instructions)					3,240	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					144	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					144	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					144	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					504	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					504	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					144	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151304		Period: From 01/01/2013 To 12/31/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/30/2014 2:52 pm	
				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	72.01	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					3,240	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					144	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					3,384	63.00
64.00	Total cost of outside supplier services (from your records)					0	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					144	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					144	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					504	101.01
101.02	Line 34 = sum of lines 27 and 31					504	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					504	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					504	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151304		Period: From 01/01/2013 To 12/31/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/30/2014 2:52 pm	
		Speech Pathology		Cost			
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					46	1.00
2.00	Line 1 multiplied by 15 hours per week					690	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					78	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	309.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	69.21	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.61	34.61	0.00			11.00
12.00	Number of travel hours (provider site)	0	64	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	5,196	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					21,403	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					21,403	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					21,403	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					69.21	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					47,755	22.00
23.00	Total salary equivalency (see instructions)					47,755	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					2,700	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					2,700	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					2,700	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					4,429	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					4,429	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					2,700	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151304				Period: From 01/01/2013 To 12/31/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/30/2014 2:52 pm	
						Speech Pathology		Cost	
								1.00	
46.00 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)								0 46.00	
		Therapists	Assistants	Aides	Trainees	Total			
		1.00	2.00	3.00	4.00	5.00			
PART V - OVERTIME COMPUTATION									
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT									
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00		51.00	
DETERMINATION OF OVERTIME ALLOWANCE									
52.00	Adjusted hourly salary equivalency amount (see instructions)	69.21	0.00	0.00	0.00			52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0			53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0			54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0			55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0			56.00	
								1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT									
57.00	Salary equivalency amount (from line 23)							47,755	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))							2,700	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)							0	59.00
60.00	Overtime allowance (from column 5, line 56)							0	60.00
61.00	Equipment cost (see instructions)							0	61.00
62.00	Supplies (see instructions)							0	62.00
63.00	Total allowance (sum of lines 57-62)							50,455	63.00
64.00	Total cost of outside supplier services (from your records)							22,580	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)							0	65.00
LINE 33 CALCULATION									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others							2,700	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27							2,700	100.02
LINE 34 CALCULATION									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							4,429	101.01
101.02	Line 34 = sum of lines 27 and 31							4,429	101.02
LINE 35 CALCULATION									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							4,429	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others							0	102.01
102.02	Line 35 = sum of lines 31 and 32							4,429	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151304

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2014 2:52 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	1,544,983	1,544,983				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,527,090	12,802	2,539,892			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,614,465	265,631	444,772	3,324,868	3,324,868	5.00
7.00 00700	OPERATION OF PLANT	687,572	144,974	42,299	874,845	176,763	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	58,333	5,690	0	64,023	12,936	8.00
9.00 00900	HOUSEKEEPING	315,968	27,757	54,305	398,030	80,422	9.00
10.00 01000	DIETARY	150,923	53,495	19,177	223,595	45,178	10.00
11.00 01100	CAFETERIA	229,587	17,761	51,980	299,328	60,480	11.00
13.00 01300	NURSING ADMINISTRATION	114,153	11,822	25,419	151,394	30,589	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	108,720	38,002	10,744	157,466	31,816	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	360,686	27,449	54,053	442,188	89,345	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	881,646	119,216	184,361	1,185,223	239,475	30.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	398,201	104,338	86,957	589,496	119,108	50.00
51.00 05100	RECOVERY ROOM	36,030	12,072	7,685	55,787	11,272	51.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,176,997	145,819	176,521	1,499,337	302,943	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00 06000	LABORATORY	1,335,097	40,001	125,289	1,500,387	303,155	60.00
65.00 06500	RESPIRATORY THERAPY	98,539	2,518	20,770	121,827	24,615	65.00
66.00 06600	PHYSICAL THERAPY	356,830	64,913	64,842	486,585	98,315	66.00
67.00 06700	OCCUPATIONAL THERAPY	205,784	24,604	46,014	276,402	55,847	67.00
68.00 06800	SPEECH PATHOLOGY	3,522	2,384	788	6,694	1,353	68.00
69.00 06900	ELECTROCARDIOLOGY	175,491	7,727	38,673	221,891	44,833	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	130,861	0	0	130,861	26,441	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	95,854	0	0	95,854	19,367	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2,078,044	6,843	82,465	2,167,352	437,916	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	1,668,430	302,598	696,589	2,667,617	538,994	90.00
91.00 09100	EMERGENCY	1,711,500	74,159	162,662	1,948,321	393,660	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	641,222	24,604	127,529	793,355	160,298	95.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	19,706,528	1,537,179	2,523,894	19,682,726	3,305,121	118.00
NONREIMBURSABLE COST CENTERS							
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01 19301	FOUNDATION	46,507	4,825	10,402	61,734	12,473	193.01
193.02 19302	OCCUPATIONAL MEDICINE	27,427	2,979	5,596	36,002	7,274	193.02
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments				0	0	200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	19,780,462	1,544,983	2,539,892	19,780,462	3,324,868	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151304

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

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Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	1,051,608				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,335	82,294			8.00
9.00	00900	HOUSEKEEPING	26,025	5,776	510,253		9.00
10.00	01000	DIETARY	50,158	2,368	25,085	346,384	10.00
11.00	01100	CAFETERIA	16,653	0	8,329	0	11.00
13.00	01300	NURSING ADMINISTRATION	11,084	0	5,543	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	35,632	0	17,820	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25,737	0	12,872	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	111,779	53,660	55,904	346,384	46,898
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	97,829	5,386	48,927	0	14,412
51.00	05100	RECOVERY ROOM	11,318	0	5,661	0	2,288
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	136,723	3,480	68,379	0	35,459
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
60.00	06000	LABORATORY	37,506	0	18,758	0	32,256
65.00	06500	RESPIRATORY THERAPY	2,361	693	1,181	0	4,575
66.00	06600	PHYSICAL THERAPY	60,864	1,620	30,440	0	12,354
67.00	06700	OCCUPATIONAL THERAPY	23,069	745	11,538	0	6,406
68.00	06800	SPEECH PATHOLOGY	2,235	32	1,118	0	0
69.00	06900	ELECTROCARDIOLOGY	7,245	0	3,624	0	7,321
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	6,416	0	3,209	0	11,896
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	283,719	0	141,893	0	103,861
91.00	09100	EMERGENCY	69,533	8,534	34,775	0	37,518
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	23,069	0	11,538	0	42,780
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,044,290	82,294	506,594	346,384	382,502
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	FOUNDATION	4,524	0	2,262	0	2,288
193.02	19302	OCCUPATIONAL MEDICINE	2,794	0	1,397	0	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,051,608	82,294	510,253	346,384	384,790

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151304

Period:
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	2,391,072	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	974,873	50.00
51.00	05100 RECOVERY ROOM	91,111	51.00
53.00	05300 ANESTHESIOLOGY	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,125,126	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	55.00
60.00	06000 LABORATORY	1,990,226	60.00
65.00	06500 RESPIRATORY THERAPY	166,119	65.00
66.00	06600 PHYSICAL THERAPY	691,803	66.00
67.00	06700 OCCUPATIONAL THERAPY	374,068	67.00
68.00	06800 SPEECH PATHOLOGY	11,432	68.00
69.00	06900 ELECTROCARDIOLOGY	285,247	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	189,992	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	141,241	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,634,049	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	3,757,902	90.00
91.00	09100 EMERGENCY	2,788,363	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	1,036,431	95.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	19,649,055	118.00
NONREIMBURSABLE COST CENTERS			
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	192.00
193.00	19300 NONPAID WORKERS	0	193.00
193.01	19301 FOUNDATION	83,291	193.01
193.02	19302 OCCUPATIONAL MEDICINE	48,116	193.02
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	194.00
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	19,780,462	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151304

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

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	12,802	12,802	12,802		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	265,631	265,631	2,241	267,872	5.00
7.00 00700	OPERATION OF PLANT	0	144,974	144,974	213	14,241	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	5,690	5,690	0	1,042	8.00
9.00 00900	HOUSEKEEPING	0	27,757	27,757	274	6,479	9.00
10.00 01000	DIETARY	0	53,495	53,495	97	3,640	10.00
11.00 01100	CAFETERIA	0	17,761	17,761	262	4,872	11.00
13.00 01300	NURSING ADMINISTRATION	0	11,822	11,822	128	2,464	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	38,002	38,002	54	2,563	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	27,449	27,449	272	7,198	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	119,216	119,216	929	19,293	30.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	104,338	104,338	438	9,596	50.00
51.00 05100	RECOVERY ROOM	0	12,072	12,072	39	908	51.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	145,819	145,819	890	24,406	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00 06000	LABORATORY	0	40,001	40,001	631	24,423	60.00
65.00 06500	RESPIRATORY THERAPY	0	2,518	2,518	105	1,983	65.00
66.00 06600	PHYSICAL THERAPY	0	64,913	64,913	327	7,921	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	24,604	24,604	232	4,499	67.00
68.00 06800	SPEECH PATHOLOGY	0	2,384	2,384	4	109	68.00
69.00 06900	ELECTROCARDIOLOGY	0	7,727	7,727	195	3,612	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	2,130	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,560	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	6,843	6,843	416	35,280	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	0	302,598	302,598	3,512	43,433	90.00
91.00 09100	EMERGENCY	0	74,159	74,159	820	31,715	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	0	24,604	24,604	643	12,914	95.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,537,179	1,537,179	12,722	266,281	118.00
NONREIMBURSABLE COST CENTERS							
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01 19301	FOUNDATION	0	4,825	4,825	52	1,005	193.01
193.02 19302	OCCUPATIONAL MEDICINE	0	2,979	2,979	28	586	193.02
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
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	1,544,983	1,544,983	12,802	267,872	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151304

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

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Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	159,428				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	809	7,541			8.00
9.00	00900	HOUSEKEEPING	3,946	529	38,985		9.00
10.00	01000	DIETARY	7,604	217	1,917	66,970	10.00
11.00	01100	CAFETERIA	2,525	0	636	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,680	0	424	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,402	0	1,362	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,902	0	983	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	16,946	4,917	4,271	66,970	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	14,831	494	3,738	0	50.00
51.00	05100	RECOVERY ROOM	1,716	0	432	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,728	319	5,224	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
60.00	06000	LABORATORY	5,686	0	1,433	0	60.00
65.00	06500	RESPIRATORY THERAPY	358	64	90	0	65.00
66.00	06600	PHYSICAL THERAPY	9,227	148	2,326	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,497	68	882	0	67.00
68.00	06800	SPEECH PATHOLOGY	339	3	85	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,098	0	277	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	973	0	245	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	43,013	0	10,841	0	90.00
91.00	09100	EMERGENCY	10,541	782	2,657	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	3,497	0	882	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	158,318	7,541	38,705	66,970	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	FOUNDATION	686	0	173	0	193.01
193.02	19302	OCCUPATIONAL MEDICINE	424	0	107	0	193.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	159,428	7,541	38,985	66,970	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151304

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From 01/01/2013
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Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	14.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	16,781					13.00
14.00	01400	0	47,693				14.00
16.00	01600	0	150	41,038			16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	7,300	2,210	17,632	262,860	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,172	3,481	3,878	143,942	0	50.00
51.00	05100	359	87	0	15,768	0	51.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	2,248	4,695	206,730	0	54.00
55.00	05500	0	0	0	0	0	55.00
60.00	06000	0	18,931	0	93,289	0	60.00
65.00	06500	720	181	87	6,416	0	65.00
66.00	06600	0	313	0	86,012	0	66.00
67.00	06700	0	12	0	34,228	0	67.00
68.00	06800	0	0	0	2,924	0	68.00
69.00	06900	0	64	0	13,469	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	6,304	0	8,434	0	71.00
72.00	07200	0	5,018	0	6,578	0	72.00
73.00	07300	369	541	0	45,473	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	4,208	0	414,636	0	90.00
91.00	09100	5,861	2,778	14,746	146,600	0	91.00
92.00	09200					0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	1,040	0	46,477	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		16,781	47,566	41,038	1,533,836	0	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	2	0	6,898	0	193.01
193.02	19302	0	125	0	4,249	0	193.02
194.00	07950	0	0	0	0	0	194.00
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		16,781	47,693	41,038	1,544,983	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151304

Period:
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	262,860	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	143,942	50.00
51.00	05100 RECOVERY ROOM	15,768	51.00
53.00	05300 ANESTHESIOLOGY	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	206,730	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	55.00
60.00	06000 LABORATORY	93,289	60.00
65.00	06500 RESPIRATORY THERAPY	6,416	65.00
66.00	06600 PHYSICAL THERAPY	86,012	66.00
67.00	06700 OCCUPATIONAL THERAPY	34,228	67.00
68.00	06800 SPEECH PATHOLOGY	2,924	68.00
69.00	06900 ELECTROCARDIOLOGY	13,469	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8,434	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	6,578	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	45,473	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	414,636	90.00
91.00	09100 EMERGENCY	146,600	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	46,477	95.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,533,836	118.00
NONREIMBURSABLE COST CENTERS			
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	192.00
193.00	19300 NONPAID WORKERS	0	193.00
193.01	19301 FOUNDATION	6,898	193.01
193.02	19302 OCCUPATIONAL MEDICINE	4,249	193.02
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	194.00
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	1,544,983	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151304

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

Worksheet B-1
Date/Time Prepared:
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Cost Center Description	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADM INI STRATI VE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)					
	1.00	4.00	5A	5.00	7.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	80,375				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	666	11,346,776			4.00
5.00 00500	ADM INI STRATI VE & GENERAL	13,819	1,986,982	-3,324,868	16,455,594	5.00
7.00 00700	OPERATION OF PLANT	7,542	188,966	0	874,845	58,348
8.00 00800	LAUNDRY & LINEN SERVICE	296	0	0	64,023	296
9.00 00900	HOUSEKEEPING	1,444	242,603	0	398,030	1,444
10.00 01000	DI ETARY	2,783	85,672	0	223,595	2,783
11.00 01100	CAFETERIA	924	232,217	0	299,328	924
13.00 01300	NURSI NG ADM INI STRATI ON	615	113,558	0	151,394	615
14.00 01400	CENTRAL SERVI CES & SUPPLY	1,977	47,998	0	157,466	1,977
16.00 01600	MEDICAL RECORDS & LIBRARY	1,428	241,476	0	442,188	1,428
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDI ATRICS	6,202	823,619	0	1,185,223	6,202
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	5,428	388,472	0	589,496	5,428
51.00 05100	RECOVERY ROOM	628	34,333	0	55,787	628
53.00 05300	ANESTHESI OLOGY	0	0	0	0	0
54.00 05400	RADI OLOGY-DI AGNOSTIC	7,586	788,592	0	1,499,337	7,586
55.00 05500	RADI OLOGY-THERAPEUTI C	0	0	0	0	0
60.00 06000	LABORATORY	2,081	559,716	0	1,500,387	2,081
65.00 06500	RESPI RATORY THERAPY	131	92,790	0	121,827	131
66.00 06600	PHYSI CAL THERAPY	3,377	289,675	0	486,585	3,377
67.00 06700	OCCUPATI ONAL THERAPY	1,280	205,562	0	276,402	1,280
68.00 06800	SPEECH PATHOLOGY	124	3,522	0	6,694	124
69.00 06900	ELECTROCARDI OLOGY	402	172,769	0	221,891	402
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	130,861	0
72.00 07200	IMPL. DEV. CHARGED TO PATI ENT	0	0	0	95,854	0
73.00 07300	DRUGS CHARGED TO PATI ENTS	356	368,404	0	2,167,352	356
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINI C	15,742	3,111,976	0	2,667,617	15,742
91.00 09100	EMERGENCY	3,858	726,678	0	1,948,321	3,858
92.00 09200	OBSERVATI ON BEDS (NON-DI STI NCT PART)					
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVI CES	1,280	569,726	0	793,355	1,280
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	79,969	11,275,306	-3,324,868	16,357,858	57,942
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0	0
193.00 19300	NONPAID WORKERS	0	0	0	0	0
193.01 19301	FOUNDATI ON	251	46,470	0	61,734	251
193.02 19302	OCCUPATI ONAL MEDI CI NE	155	25,000	0	36,002	155
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	1,544,983	2,539,892		3,324,868	1,051,608
203.00	Unit cost multiplier (Wkst. B, Part I)	19.222184	0.223843		0.202051	18.023034
204.00	Cost to be allocated (per Wkst. B, Part II)		12,802		267,872	159,428
205.00	Unit cost multiplier (Wkst. B, Part II)		0.001128		0.016278	2.732364

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151304

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

Worksheet B-1
Date/Time Prepared:
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Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)		
		8.00	9.00	10.00	11.00	13.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
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	28,495				8.00	
9.00	00900	HOUSEKEEPING	2,000	56,608			9.00	
10.00	01000	DIETARY	820	2,783	100		10.00	
11.00	01100	CAFETERIA	0	924	0	1,682	11.00	
13.00	01300	NURSING ADMINISTRATION	0	615	0	97,957	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,977	0	20	14.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,428	0	70	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,580	6,202	100	205	42,621	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,865	5,428	0	63	12,676	50.00
51.00	05100	RECOVERY ROOM	0	628	0	10	2,096	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,205	7,586	0	155	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	2,081	0	141	0	60.00
65.00	06500	RESPIRATORY THERAPY	240	131	0	20	4,200	65.00
66.00	06600	PHYSICAL THERAPY	561	3,377	0	54	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	258	1,280	0	28	0	67.00
68.00	06800	SPEECH PATHOLOGY	11	124	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	402	0	32	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	356	0	52	2,154	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	15,742	0	454	0	90.00
91.00	09100	EMERGENCY	2,955	3,858	0	164	34,210	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	1,280	0	187	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	28,495	56,202	100	1,672	97,957	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	0	251	0	10	0	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	155	0	0	0	193.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	82,294	510,253	346,384	384,790	202,499	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.888015	9.013797	3,463.840000	228.769322	2.067223	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	7,541	38,985	66,970	26,056	16,781	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.264643	0.688684	669.700000	15.491082	0.171310	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151304

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

Worksheet B-1
Date/Time Prepared:
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Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		14.00	16.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	903,660	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,849 94,400	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	41,869 40,560	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	65,957 8,920	50.00
51.00	05100	RECOVERY ROOM	1,651 0	51.00
53.00	05300	ANESTHESIOLOGY	0 0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,591 10,800	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0 0	55.00
60.00	06000	LABORATORY	358,692 0	60.00
65.00	06500	RESPIRATORY THERAPY	3,438 200	65.00
66.00	06600	PHYSICAL THERAPY	5,939 0	66.00
67.00	06700	OCCUPATIONAL THERAPY	222 0	67.00
68.00	06800	SPEECH PATHOLOGY	0 0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,218 0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0 0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	119,447 0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	95,076 0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,255 0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	79,724 0	90.00
91.00	09100	EMERGENCY	52,627 33,920	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	19,699 0	95.00
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	901,254 94,400	118.00
NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0 0	192.00
193.00	19300	NONPAID WORKERS	0 0	193.00
193.01	19301	FOUNDATION	36 0	193.01
193.02	19302	OCCUPATIONAL MEDICINE	2,370 0	193.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0 0	194.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	247,309 586,936	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.273675 6.217542	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	47,693 41,038	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.052778 0.434725	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151304

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

Worksheet C
Part I
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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2,391,072		2,391,072	0	0 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	974,873		974,873	0	0 50.00
51.00	05100 RECOVERY ROOM	91,111		91,111	0	0 51.00
53.00	05300 ANESTHESIOLOGY	0		0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,125,126		2,125,126	0	0 54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0		0	0	0 55.00
60.00	06000 LABORATORY	1,990,226		1,990,226	0	0 60.00
65.00	06500 RESPIRATORY THERAPY	166,119	0	166,119	0	0 65.00
66.00	06600 PHYSICAL THERAPY	691,803	0	691,803	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	374,068	0	374,068	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	11,432	0	11,432	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	285,247		285,247	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	189,992		189,992	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	141,241		141,241	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,634,049		2,634,049	0	0 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	3,757,902		3,757,902	0	0 90.00
91.00	09100 EMERGENCY	2,788,363		2,788,363	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	336,682		336,682	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	1,036,431		1,036,431	0	0 95.00
200.00	Subtotal (see instructions)	19,985,737	0	19,985,737	0	0 200.00
201.00	Less Observation Beds	336,682		336,682	0	0 201.00
202.00	Total (see instructions)	19,649,055	0	19,649,055	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151304	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/30/2014 2:52 pm
		Title XVIII	Hospital	Cost

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	1,895,829		1,895,829			30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	88,133	2,486,204	2,574,337	0.378689	0.000000	50.00
51.00 05100 RECOVERY ROOM	7,290	454,841	462,131	0.197154	0.000000	51.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	597,724	12,001,799	12,599,523	0.168667	0.000000	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
60.00 06000 LABORATORY	739,602	8,822,373	9,561,975	0.208140	0.000000	60.00
65.00 06500 RESPIRATORY THERAPY	214,040	215,639	429,679	0.386612	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	246,451	1,073,142	1,319,593	0.524255	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	161,530	594,072	755,602	0.495060	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	10,570	62,810	73,380	0.155792	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	158,495	1,821,883	1,980,378	0.144037	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	111,469	1,824,397	1,935,866	0.098143	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	27,112	359,241	386,353	0.365575	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	870,060	5,255,368	6,125,428	0.430019	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	1,406,476	1,406,476	2.671856	0.000000	90.00
91.00 09100 EMERGENCY	64,282	4,193,084	4,257,366	0.654950	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	841,456	841,456	0.400118	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0	1,114,608	1,114,608	0.929861	0.000000	95.00
200.00	Subtotal (see instructions)	5,192,587	42,527,393			200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	5,192,587	42,527,393			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151304

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

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000			55.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
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: 151304

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

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2,391,072		2,391,072	0	2,391,072 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	974,873		974,873	0	974,873 50.00
51.00	05100 RECOVERY ROOM	91,111		91,111	0	91,111 51.00
53.00	05300 ANESTHESIOLOGY	0		0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,125,126		2,125,126	0	2,125,126 54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0		0	0	0 55.00
60.00	06000 LABORATORY	1,990,226		1,990,226	0	1,990,226 60.00
65.00	06500 RESPIRATORY THERAPY	166,119	0	166,119	0	166,119 65.00
66.00	06600 PHYSICAL THERAPY	691,803	0	691,803	0	691,803 66.00
67.00	06700 OCCUPATIONAL THERAPY	374,068	0	374,068	0	374,068 67.00
68.00	06800 SPEECH PATHOLOGY	11,432	0	11,432	0	11,432 68.00
69.00	06900 ELECTROCARDIOLOGY	285,247		285,247	0	285,247 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	189,992		189,992	0	189,992 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	141,241		141,241	0	141,241 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,634,049		2,634,049	0	2,634,049 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	3,757,902		3,757,902	0	3,757,902 90.00
91.00	09100 EMERGENCY	2,788,363		2,788,363	0	2,788,363 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	336,682		336,682		336,682 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	1,036,431		1,036,431	0	1,036,431 95.00
200.00	Subtotal (see instructions)	19,985,737	0	19,985,737	0	19,985,737 200.00
201.00	Less Observation Beds	336,682		336,682		336,682 201.00
202.00	Total (see instructions)	19,649,055	0	19,649,055	0	19,649,055 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151304

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

Worksheet C
Part I
Date/Time Prepared:
5/30/2014 2:52 pm

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
Title XIX Hospital Cost						
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	1,895,829		1,895,829			30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	88,133	2,486,204	2,574,337	0.378689	0.000000	50.00
51.00 05100 RECOVERY ROOM	7,290	454,841	462,131	0.197154	0.000000	51.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	597,724	12,001,799	12,599,523	0.168667	0.000000	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
60.00 06000 LABORATORY	739,602	8,822,373	9,561,975	0.208140	0.000000	60.00
65.00 06500 RESPIRATORY THERAPY	214,040	215,639	429,679	0.386612	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	246,451	1,073,142	1,319,593	0.524255	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	161,530	594,072	755,602	0.495060	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	10,570	62,810	73,380	0.155792	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	158,495	1,821,883	1,980,378	0.144037	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	111,469	1,824,397	1,935,866	0.098143	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	27,112	359,241	386,353	0.365575	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	870,060	5,255,368	6,125,428	0.430019	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	1,406,476	1,406,476	2.671856	0.000000	90.00
91.00 09100 EMERGENCY	64,282	4,193,084	4,257,366	0.654950	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	841,456	841,456	0.400118	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0	1,114,608	1,114,608	0.929861	0.000000	95.00
200.00	Subtotal (see instructions)	5,192,587	42,527,393			200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	5,192,587	42,527,393			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151304	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/30/2014 2:52 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS		30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.000000	50.00
51.00	05100 RECOVERY ROOM	0.000000	51.00
53.00	05300 ANESTHESIOLOGY	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	55.00
60.00	06000 LABORATORY	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.000000	90.00
91.00	09100 EMERGENCY	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0.000000	95.00
200.00	Subtotal (see instructions)		200.00
201.00	Less Observation Beds		201.00
202.00	Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151304

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

Worksheet D
Part II
Date/Time Prepared:
5/30/2014 2:52 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	143,942	2,574,337	0.055914	45,961	2,570	50.00
51.00	05100 RECOVERY ROOM	15,768	462,131	0.034120	1,527	52	51.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	206,730	12,599,523	0.016408	318,738	5,230	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
60.00	06000 LABORATORY	93,289	9,561,975	0.009756	436,082	4,254	60.00
65.00	06500 RESPIRATORY THERAPY	6,416	429,679	0.014932	132,960	1,985	65.00
66.00	06600 PHYSICAL THERAPY	86,012	1,319,593	0.065181	82,642	5,387	66.00
67.00	06700 OCCUPATIONAL THERAPY	34,228	755,602	0.045299	57,812	2,619	67.00
68.00	06800 SPEECH PATHOLOGY	2,924	73,380	0.039847	5,574	222	68.00
69.00	06900 ELECTROCARDIOLOGY	13,469	1,980,378	0.006801	105,862	720	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8,434	1,935,866	0.004357	64,388	281	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	6,578	386,353	0.017026	19,762	336	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	45,473	6,125,428	0.007424	481,007	3,571	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	414,636	1,406,476	0.294805	0	0	90.00
91.00	09100 EMERGENCY	146,600	4,257,366	0.034434	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	841,456	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	1,224,499	44,709,543		1,752,315	27,227	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151304

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

Worksheet D
Part IV
Date/Time Prepared:
5/30/2014 2:52 pm

Cost Center Description			Title XVIII				Hospital	
			Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Cost
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
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: 151304

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

Worksheet D
Part IV
Date/Time Prepared:
5/30/2014 2:52 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Cost
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	2,574,337	0.000000	0.000000	45,961	50.00
51.00	05100 RECOVERY ROOM	0	462,131	0.000000	0.000000	1,527	51.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	12,599,523	0.000000	0.000000	318,738	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
60.00	06000 LABORATORY	0	9,561,975	0.000000	0.000000	436,082	60.00
65.00	06500 RESPIRATORY THERAPY	0	429,679	0.000000	0.000000	132,960	65.00
66.00	06600 PHYSICAL THERAPY	0	1,319,593	0.000000	0.000000	82,642	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	755,602	0.000000	0.000000	57,812	67.00
68.00	06800 SPEECH PATHOLOGY	0	73,380	0.000000	0.000000	5,574	68.00
69.00	06900 ELECTROCARDIOLOGY	0	1,980,378	0.000000	0.000000	105,862	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,935,866	0.000000	0.000000	64,388	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	386,353	0.000000	0.000000	19,762	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6,125,428	0.000000	0.000000	481,007	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	1,406,476	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	4,257,366	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	841,456	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	44,709,543			1,752,315	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151304

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

Worksheet D
Part IV
Date/Time Prepared:
5/30/2014 2:52 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)	Hospital	Cost
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0	0		51.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0		55.00
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
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151304	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/30/2014 2:52 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.378689	0	1,005,683	0	0
51.00 05100 RECOVERY ROOM	0.197154	0	119,622	0	0
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.168667	0	4,252,138	0	0
55.00 05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0
60.00 06000 LABORATORY	0.208140	0	3,492,406	0	0
65.00 06500 RESPIRATORY THERAPY	0.386612	0	69,302	0	0
66.00 06600 PHYSICAL THERAPY	0.524255	0	351,739	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.495060	0	233,732	0	0
68.00 06800 SPEECH PATHOLOGY	0.155792	0	3,647	0	0
69.00 06900 ELECTROCARDIOLOGY	0.144037	0	896,662	0	0
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.098143	0	390,357	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.365575	0	143,710	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.430019	0	2,696,963	10,927	0
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	2.671856	0	277,889	7,975	0
91.00 09100 EMERGENCY	0.654950	0	1,003,564	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.400118	0	421,356	0	0
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES	0.929861	0	0	0	0
200.00 Subtotal (see instructions)		0	15,358,770	18,902	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00 Net Charges (line 200 +/- line 201)		0	15,358,770	18,902	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151304	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/30/2014 2:52 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	380,841	0		50.00
51.00 05100 RECOVERY ROOM	23,584	0		51.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	717,195	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
60.00 06000 LABORATORY	726,909	0		60.00
65.00 06500 RESPIRATORY THERAPY	26,793	0		65.00
66.00 06600 PHYSICAL THERAPY	184,401	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	115,711	0		67.00
68.00 06800 SPEECH PATHOLOGY	568	0		68.00
69.00 06900 ELECTROCARDIOLOGY	129,153	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	38,311	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	52,537	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,159,745	4,699		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	742,479	21,308		90.00
91.00 09100 EMERGENCY	657,284	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	168,592	0		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES	0	0		95.00
200.00 Subtotal (see instructions)	5,124,103	26,007		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0		201.00
202.00 Net Charges (line 200 +/- line 201)	5,124,103	26,007		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151304	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/30/2014 2:52 pm
		Component CCN: 15Z304	Title XVIII	Swing Beds - SNF Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.378689	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.197154	0	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.168667	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	55.00
60.00	06000 LABORATORY	0.208140	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.386612	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.524255	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.495060	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.155792	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.144037	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.098143	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.365575	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.430019	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	2.671856	0	0	0	90.00
91.00	09100 EMERGENCY	0.654950	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.400118	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0.929861	0	0	0	95.00
200.00	Subtotal (see instructions)		0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151304 Component CCN: 15Z304	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/30/2014 2:52 pm
Title XVII		Swing Beds - SNF	Cost

Cost Center Description	Costs			Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0	0	95.00
200.00	Subtotal (see instructions)	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151304	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/30/2014 2:52 pm
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,339	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,708	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,392	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		523	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		108	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,015	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)		513	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		130.15	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,391,072	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)		14,056	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)		571,286	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,819,786	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)		1,819,786	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,065.45	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,081,432	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,081,432	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151304	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/30/2014 2:52 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
Title XVIII		1.00	2.00	3.00	4.00	5.00
Hospital						
Cost						
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)					522,083 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,603,515 49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0 54.00
55.00	Target amount per discharge					0.00 55.00
56.00	Target amount (line 54 x line 55)					0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00	Bonus payment (see instructions)					0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00	Relief payment (see instructions)					0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					546,576 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)					546,576 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)					316 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,065.45 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					336,682 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151304		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/30/2014 2:52 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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151304	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/30/2014 2:52 pm
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,339	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,708	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,392	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		523	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		108	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)		65	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,391,072	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)		560,525	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,830,547	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)		1,830,547	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,071.75	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		69,664	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)		69,664	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151304		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
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)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	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							
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					53,667	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					123,331	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					316	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,071.75	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					338,673	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151304		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/30/2014 2:52 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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151304	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/30/2014 2:52 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		1,169,184		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.378689	45,961	17,405	50.00
51.00	05100 RECOVERY ROOM	0.197154	1,527	301	51.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.168667	318,738	53,761	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
60.00	06000 LABORATORY	0.208140	436,082	90,766	60.00
65.00	06500 RESPIRATORY THERAPY	0.386612	132,960	51,404	65.00
66.00	06600 PHYSICAL THERAPY	0.524255	82,642	43,325	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.495060	57,812	28,620	67.00
68.00	06800 SPEECH PATHOLOGY	0.155792	5,574	868	68.00
69.00	06900 ELECTROCARDIOLOGY	0.144037	105,862	15,248	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.098143	64,388	6,319	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.365575	19,762	7,224	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.430019	481,007	206,842	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	2.671856	0	0	90.00
91.00	09100 EMERGENCY	0.654950	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.400118	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		1,752,315	522,083	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)		1,752,315		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151304	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3	
		Component CCN: 15Z304		Date/Time Prepared: 5/30/2014 2:52 pm	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS			0	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.378689	1,593	603	50.00
51.00	05100 RECOVERY ROOM	0.197154	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.168667	17,054	2,876	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
60.00	06000 LABORATORY	0.208140	37,514	7,808	60.00
65.00	06500 RESPIRATORY THERAPY	0.386612	32,035	12,385	65.00
66.00	06600 PHYSICAL THERAPY	0.524255	113,300	59,398	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.495060	70,319	34,812	67.00
68.00	06800 SPEECH PATHOLOGY	0.155792	2,918	455	68.00
69.00	06900 ELECTROCARDIOLOGY	0.144037	4,326	623	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.098143	6,602	648	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.365575	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.430019	107,069	46,042	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	2.671856	0	0	90.00
91.00	09100 EMERGENCY	0.654950	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.400118	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		392,730	165,650	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)		392,730		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151304	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/30/2014 2:52 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		81,833		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.378689	5,840	2,212	50.00
51.00	05100 RECOVERY ROOM	0.197154	1,248	246	51.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.168667	55,892	9,427	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
60.00	06000 LABORATORY	0.208140	47,450	9,876	60.00
65.00	06500 RESPIRATORY THERAPY	0.386612	9,902	3,828	65.00
66.00	06600 PHYSICAL THERAPY	0.524255	2,966	1,555	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.495060	1,477	731	67.00
68.00	06800 SPEECH PATHOLOGY	0.155792	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.144037	2,168	312	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.098143	3,301	324	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.365575	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.430019	35,433	15,237	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	2.671856	0	0	90.00
91.00	09100 EMERGENCY	0.654950	15,145	9,919	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.400118	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		180,822	53,667	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)			0	201.00
202.00	Net Charges (line 200 minus line 201)		180,822		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151304	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/30/2014 2:52 pm
		Title XVII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			5,150,110 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			5,150,110 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			5,201,611 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			45,807 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,361,037 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			2,794,767 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			2,794,767 30.00
31.00	Primary payer payments			799 31.00
32.00	Subtotal (line 30 minus line 31)			2,793,968 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			337,603 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			297,091 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			304,937 36.00
37.00	Subtotal (see instructions)			3,091,059 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			3,091,059 40.00
40.01	Sequestration adjustment (see instructions)			46,675 40.01
41.00	Interim payments			2,846,004 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			198,380 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151304

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

Worksheet E-1
Part I
Date/Time Prepared:
5/30/2014 2:52 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,255,815		2,846,004	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	07/05/2013	53,600		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)		53,600		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)		1,309,415		2,846,004	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		58,963		198,380	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,368,378		3,044,384	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151304
Component CCN: 15Z304

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

Worksheet E-1
Part I
Date/Time Prepared:
5/30/2014 2:52 pm

Title XVIII Swing Beds - SNF Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		634,412		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)		634,412		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		64,746		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		699,158		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 151304	Period: From 01/01/2013 To 12/31/2013	Worksheet E-1 Part II Date/Time Prepared: 5/30/2014 2:52 pm
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			451 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			1,015 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			45 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			1,392 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			47,719,980 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			786,985 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			0 8.00
9.00	Sequestration adjustment amount (see instructions)			0 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			0 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			0 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 151304	Period: From 01/01/2013 To 12/31/2013	Worksheet E-2
		Component CCN: 15Z304		Date/Time Prepared: 5/30/2014 2:52 pm
		Title XVIII	Swing Beds - SNF	Cost
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	552,042	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 6 and 7, line 202 for Part B) (For CAH, see instructions)	167,307	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	513	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	719,349	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	719,349	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	719,349	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	9,472	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	709,877	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	709,877	0	19.00
19.01	Sequestration adjustment (see instructions)	10,719	0	19.01
20.00	Interim payments	634,412	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21	64,746	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151304	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part V Date/Time Prepared: 5/30/2014 2:52 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services		1,603,515	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 thru 3)		1,603,515	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,619,550	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		1,619,550	19.00
20.00	Deductibles (exclude professional component)		257,942	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		1,361,608	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,361,608	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		31,533	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		27,749	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		14,583	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,389,357	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)		1,389,357	30.00
30.01	Sequestration adjustment (see instructions)		20,979	30.01
31.00	Interim payments		1,309,415	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program line 30 minus lines 30.01, 31, and 32		58,963	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		219,485	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151304	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2014 2:52 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		123,331		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		123,331	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		123,331	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		81,833		8.00
9.00	Ancillary service charges		180,822	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		262,655	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		262,655	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		139,324	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		123,331	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		123,331	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		123,331	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		123,331	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		123,331	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		123,331	0	40.00
41.00	Interim payments		143,998	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		-20,667	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0	43.00

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

Provider CCN: 151304

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

Worksheet G

Date/Time Prepared:
5/30/2014 2:52 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	4,107,750	0	0	0	1.00
2.00	Temporary investments	9,008	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,032,608	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	964,819	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)	9,114,185	0	0	0	11.00
FIXED ASSETS						
12.00	Land	188,708	0	0	0	12.00
13.00	Land improvements	318,434	0	0	0	13.00
14.00	Accumulated depreciation	-500,728	0	0	0	14.00
15.00	Buildings	14,541,359	0	0	0	15.00
16.00	Accumulated depreciation	-1,535,895	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	813,702	0	0	0	19.00
20.00	Accumulated depreciation	-188,582	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	10,900,339	0	0	0	23.00
24.00	Accumulated depreciation	-14,081,334	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	10,456,003	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	1,627,110	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,627,110	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	21,197,298	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,922,038	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,314,992	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,437,198	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,674,228	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,553,570	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,553,570	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	9,227,798	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	11,969,500	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	11,969,500	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	21,197,298	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151304

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

Worksheet G-1

Date/Time Prepared:
5/30/2014 2:52 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		11,156,060		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		813,440			2.00
3.00	Total (sum of line 1 and line 2)		11,969,500		0	3.00
4.00	Additions (credit adjustments) (specify)	0		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)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		11,969,500		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)		11,969,500		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151304

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/30/2014 2:52 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,737,285		2,737,285	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,737,285		2,737,285	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)	2,737,285		2,737,285	17.00
18.00	Ancillary services	3,232,476	34,466,644	37,699,120	18.00
19.00	Outpatient services	64,282	6,104,685	6,168,967	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	1,114,608	1,114,608	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	0	5,066,491	5,066,491	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,034,043	46,752,428	52,786,471	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		24,002,418		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)		24,002,418		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151304

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

Worksheet G-3

Date/Time Prepared:
5/30/2014 2:52 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	52,786,471	1.00
2.00	Less contractual allowances and discounts on patients' accounts	31,190,558	2.00
3.00	Net patient revenues (line 1 minus line 2)	21,595,913	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	24,002,418	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,406,505	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	1,144,856	24.00
24.01	INVESTMENT INCOME	206,827	24.01
24.02	CONTRIBUTIONS	1,866,262	24.02
24.03	OTHER NONOPERATING INCOME	2,000	24.03
25.00	Total other income (sum of lines 6-24)	3,219,945	25.00
26.00	Total (line 5 plus line 25)	813,440	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)	813,440	29.00