

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: 151326	Period: From 09/01/2012 To 08/31/2013	Worksheet S Parts I-III Date/Time Prepared: 1/27/2014 3:36 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 1/27/2014	Time: 3:36 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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 UNION HOSPITAL CLINTON (151326) for the cost reporting period beginning 09/01/2012 and ending 08/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____ Title

_____ Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	8,579	233,328	23,657	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	24,910	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
200.00 Total	0	33,489	233,328	23,657	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151326			Period: From 09/01/2012 To 08/31/2013		Worksheet S-2 Part I Date/Time Prepared: 1/27/2014 3:35 pm						
1.00		2.00		3.00		4.00							
Hospital and Hospital Health Care Complex Address:													
1.00	Street: 801 SOUTH MAIN STREET			PO Box:						1.00			
2.00	City: CLINTON			State: IN		Zip Code: 47842-		County: VERMILION		2.00			
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)					
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:													
3.00	Hospital		UNION HOSPITAL CLINTON	151326	45460	1	03/01/2005	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		SWING BEDS	152326	45460		03/01/2005	N	0	0	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)						09/01/2012	08/31/2013		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	N		22.00			
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.						3	N		23.00			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days						
		1.00	2.00	3.00	4.00	5.00	6.00						
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.						0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.						0	0	0	0	0	0	25.00
							Urban/Rural S	Date of Geogr					
							1.00	2.00					
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						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.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00
61.01	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 and general surgery) added as a result of section 5503. (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	
<u>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.</u>						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00
			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.			Y		N	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	97.00
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			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	N	N	N	109.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1			118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	81,330	0	0		118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N			118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N		N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y			121.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y		15H043	140.00

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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: UNION HOSPITAL, INC.	Contractor's Name: N/A		Contractor's Number: N/A		141.00								
142.00	Street: 1606 NORTH SEVENTH ST	PO Box:				142.00								
143.00	City: TERRE HAUTE	State: IN		Zip Code: 47804		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)						440,683		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)						07/01/2012		09/30/2012		170.00			

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151326	Period: From 09/01/2012 To 08/31/2013	Worksheet S-2 Part II Date/Time Prepared: 1/27/2014 3:35 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			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	12/15/2013	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151326	Period: From 09/01/2012 To 08/31/2013	Worksheet S-2 Part II Date/Time Prepared: 1/27/2014 3:35 pm	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
	0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been 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			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	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.	CAROLYN	CHAPLIN		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3177137919	CCHAPLIN@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)	12/15/2013		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.	SENIOR MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet S-3
Part I
Date/Time Prepared:
1/27/2014 3:35 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	19	6,935	55,752.00	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)		19	6,935	55,752.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	6	2,190	11,136.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	66,888.00	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)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet S-3
Part I
Date/Time Prepared:
1/27/2014 3:35 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)	1,459	330	2,323			1.00
2.00 HMO and other (see instructions)	0	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	194	0	194			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	22			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,653	330	2,539			7.00
8.00 INTENSIVE CARE UNIT	285	43	464			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)	1,938	373	3,003	0.00	156.00	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	156.00	27.00
28.00 Observation Bed Days		0	981			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet S-3
Part I
Date/Time Prepared:
1/27/2014 3:35 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	581	121	999	1.00
2.00 HMO and other (see instructions)				0			2.00
3.00 HMO IPF Subprovider							3.00
4.00 HMO IRF Subprovider							4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0	581	121	999		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
33.00 LTCH non-covered days							33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151326	Period: From 09/01/2012 To 08/31/2013	Worksheet S-10 Date/Time Prepared: 1/27/2014 3:35 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)			0.314068	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			0	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?				3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			0	5.00	
6.00	Medicaid charges			0	6.00	
7.00	Medicaid cost (line 1 times line 6)			0	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)			0	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone SCHIP			0	9.00	
10.00	Stand-alone SCHIP charges			0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)			0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00	
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00	
Uncompensated care (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			0	19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility		3,642,680	0	3,642,680	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)		1,144,049	0	1,144,049	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)		1,144,049	0	1,144,049	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?					24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit				0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)				4,703,143	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)				709,674	27.00
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)				3,993,469	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)				1,254,221	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)				2,398,270	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)				2,398,270	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet A
Date/Time Prepared:
1/27/2014 3:35 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		631,160	631,160	0	631,160	1.00
2.00	00200		442,513	442,513	0	442,513	2.00
4.00	00400		0	0	0	0	4.00
5.01	00510	0	29,773	29,773	0	29,773	5.01
5.02	00511	0	445,356	445,356	0	445,356	5.02
5.03	00512	0	2,738	2,738	0	2,738	5.03
5.04	00513	474,252	81,799	556,051	0	556,051	5.04
5.05	00514	21,878	460,794	482,672	0	482,672	5.05
5.06	00560	638,562	1,598,915	2,237,477	0	2,237,477	5.06
7.00	00700	370,110	602,959	973,069	0	973,069	7.00
8.00	00800	0	1,834	1,834	0	1,834	8.00
9.00	00900	240,194	90,845	331,039	0	331,039	9.00
10.00	01000	304,534	237,455	541,989	-371,624	170,365	10.00
11.00	01100	0	0	0	371,624	371,624	11.00
13.00	01300	574,678	118,779	693,457	0	693,457	13.00
16.00	01600	193,938	85,580	279,518	0	279,518	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,459,239	437,622	1,896,861	0	1,896,861	30.00
31.00	03100	669,352	96,954	766,306	0	766,306	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	339,267	802,900	1,142,167	0	1,142,167	50.00
51.00	05100	65,531	4,802	70,333	0	70,333	51.00
51.01	05101	140,352	26,336	166,688	0	166,688	51.01
54.00	05400	1,376,361	880,814	2,257,175	0	2,257,175	54.00
56.00	05600	0	123,753	123,753	0	123,753	56.00
60.00	06000	0	1,072,981	1,072,981	0	1,072,981	60.00
62.00	06200	0	119,488	119,488	0	119,488	62.00
65.00	06500	326,068	112,478	438,546	0	438,546	65.00
66.00	06600	296,775	48,691	345,466	0	345,466	66.00
67.00	06700	103,650	16,338	119,988	0	119,988	67.00
68.00	06800	13,114	5,712	18,826	0	18,826	68.00
69.00	06900	117,253	61,060	178,313	0	178,313	69.00
71.00	07100	0	93,884	93,884	0	93,884	71.00
72.00	07200	0	18,914	18,914	0	18,914	72.00
73.00	07300	398,336	781,300	1,179,636	0	1,179,636	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	8,238	1,413	9,651	0	9,651	90.00
91.00	09100	1,255,768	307,548	1,563,316	0	1,563,316	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		9,387,450	9,843,488	19,230,938	0	19,230,938	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	310,733	244,735	555,468	0	555,468	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00		9,698,183	10,088,223	19,786,406	0	19,786,406	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet A
Date/Time Prepared:
1/27/2014 3:35 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	977,168	1,608,328	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	442,513	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,345,313	1,345,313	4.00
5.01	00510	NONPATIENT TELEPHONES	35,043	64,816	5.01
5.02	00511	DATA PROCESSING	1,315,744	1,761,100	5.02
5.03	00512	PURCHASING RECEIVING AND STORES	81,657	84,395	5.03
5.04	00513	ADMINISTRATIVE	0	556,051	5.04
5.05	00514	CASHIERING/ACCOUNTS RECEIVABLE	477,748	960,420	5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	-205,341	2,032,136	5.06
7.00	00700	OPERATION OF PLANT	201,508	1,174,577	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,834	8.00
9.00	00900	HOUSEKEEPING	59,297	390,336	9.00
10.00	01000	DIETARY	4,661	175,026	10.00
11.00	01100	CAFETERIA	-149,851	221,773	11.00
13.00	01300	NURSING ADMINISTRATION	68,216	761,673	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,255	292,773	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-219,953	1,676,908	30.00
31.00	03100	INTENSIVE CARE UNIT	0	766,306	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-496,448	645,719	50.00
51.00	05100	RECOVERY ROOM	232	70,565	51.00
51.01	05101	O/P TREATMENT ROOM	0	166,688	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	-599,012	1,658,163	54.00
56.00	05600	RADIOISOTOPE	0	123,753	56.00
60.00	06000	LABORATORY	45,221	1,118,202	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	119,488	62.00
65.00	06500	RESPIRATORY THERAPY	0	438,546	65.00
66.00	06600	PHYSICAL THERAPY	28,108	373,574	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,827	129,815	67.00
68.00	06800	SPEECH PATHOLOGY	1,842	20,668	68.00
69.00	06900	ELECTROCARDIOLOGY	1,115	179,428	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-42	93,842	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	18,914	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,699	1,208,335	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	9,651	90.00
91.00	09100	EMERGENCY	0	1,563,316	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,024,007	22,254,945	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	PHYSICIAN PRACTICES	0	555,468	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	194.01
194.02	07952	VPCHC	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	3,024,007	22,810,413	200.00

RECLASSIFICATIONS

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet A-6

Date/Time Prepared:
1/27/2014 3:35 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - DEFAULT					
1.00	CAFETERIA	11.00	208,809	162,815	1.00
TOTALS			208,809	162,815	
500.00	Grand Total: Increases		208,809	162,815	500.00

RECLASSIFICATIONS

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet A-6

Date/Time Prepared:
1/27/2014 3:35 pm

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - DEFAULT							
1.00	DIETARY	10.00	208,809	162,815	0	1.00	
TOTALS			208,809	162,815			
500.00	Grand Total: Decreases		208,809	162,815		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet A-7
Part I
Date/Time Prepared:
1/27/2014 3:35 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	282,637	47,662	0	47,662	0 1.00
2.00	Land Improvements	213,685	15,765	0	15,765	0 2.00
3.00	Buildings and Fixtures	8,682,105	132,705	0	132,705	0 3.00
4.00	Building Improvements	1,647,742	0	0	0	2,271 4.00
5.00	Fixed Equipment	0	0	0	0	0 5.00
6.00	Movable Equipment	5,340,565	230,253	0	230,253	12,845 6.00
7.00	HIT designated Assets	0	0	0	0	0 7.00
8.00	Subtotal (sum of lines 1-7)	16,166,734	426,385	0	426,385	15,116 8.00
9.00	Reconciling Items	0	0	0	0	0 9.00
10.00	Total (line 8 minus line 9)	16,166,734	426,385	0	426,385	15,116 10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	330,299	0			1.00
2.00	Land Improvements	229,450	0			2.00
3.00	Buildings and Fixtures	8,814,810	0			3.00
4.00	Building Improvements	1,645,471	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	5,557,973	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	16,578,003	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	16,578,003	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet A-7
Part II
Date/Time Prepared:
1/27/2014 3:35 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	629,770	0	1,390	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	442,513	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,072,283	0	1,390	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	631,160				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	442,513				2.00
3.00	Total (sum of lines 1-2)	0	1,073,673				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet A-7
Part III
Date/Time Prepared:
1/27/2014 3:35 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,608,457	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	442,513	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,050,970	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	-129	0	0	0	1,608,328	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	442,513	2.00
3.00	Total (sum of lines 1-2)	-129	0	0	0	2,050,841	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet A-8

Date/Time Prepared:
1/27/2014 3:35 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 - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0	0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0	0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0	0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0	0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0	0		0.00	0	7.00
8.00 Television and radio service (chapter 21)		0	0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0	0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-875,204	0		0.00	0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0	0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	5,901,674	0			0	12.00
13.00 Laundry and linen service		0	0		0.00	0	13.00
14.00 Cafeteria-employees and guests		0	0		0.00	0	14.00
15.00 Rental of quarters to employee and others		0	0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0	0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0	0		0.00	0	17.00
18.00 Sale of medical records and abstracts		0	0		0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0	0		0.00	0	19.00
20.00 Vending machines		0	0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0	0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0	0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	0RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	0PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	0*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	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	0OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	0ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	0SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0	0		0.00	0	32.00

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	
33.00 CHART FEE REVENUE	B	-2,431	MEDI CAL RECORDS & LIBRARY	16.00	0 33.00
34.00 DISCOUNT EARNED	B	-4	PURCHASING RECEIVING AND STORES	5.03	0 34.00
35.00 CAFETERIA REVENUE	B	-162,696	CAFETERIA	11.00	0 35.00
36.00 CAFETERIA REVENUE	B	-957	CAFETERIA	11.00	0 36.00
37.00 INTEREST OFFSET	A	-1,390	NEW CAP REL COSTS-BLDG & FIXT	1.00	11 37.00
38.00 CRNA OFFSET	A	-505,772	OPERATING ROOM	50.00	0 38.00
39.00 ADVERTISING	A	-3,294	OTHER ADMINI STRATIVE AND GENERAL	5.06	0 39.00
40.00 IHA DUES	A	-558	OTHER ADMINI STRATIVE AND GENERAL	5.06	0 40.00
41.00 MI SC REVENUE	B	-129	NEW CAP REL COSTS-BLDG & FIXT	1.00	11 41.00
42.00 MI SC REVENUE	B	-600	NONPATIENT TELEPHONES	5.01	0 42.00
43.00 MI SC REVENUE	B	-92	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0 43.00
44.00 MI SC REVENUE	B	-1,882	OTHER ADMINI STRATIVE AND GENERAL	5.06	0 44.00
45.00 MI SC REVENUE	B	-125	NURSING ADMINI STRATION	13.00	0 45.00
46.00 MI SC REVENUE	B	-6,100	RADIOLOGY-DI AGNOSTI C	54.00	0 46.00
47.00 MI SC REVENUE	B	-42	MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	71.00	0 47.00
47.01 MI SC REVENUE	B	-1,069	DRUGS CHARGED TO PATI ENTS	73.00	0 47.01
47.02 VPCHC	B	-5,697	HOUSEKEEPING	9.00	0 47.02
47.03 RENTAL REVENUE	B	-59,425	OPERATION OF PLANT	7.00	0 47.03
47.04 HAF	A	-1,238,553	OTHER ADMINI STRATIVE AND GENERAL	5.06	0 47.04
47.09 E. H. R. DEPRECIATION	A	-11,647	NEW CAP REL COSTS-BLDG & FIXT	1.00	9 47.09
47.10		0		0.00	0 47.10
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		3,024,007			50.00

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

Provider CCN: 151326

Period: From 09/01/2012 To 08/31/2013

Worksheet A-8-1

Date/Time Prepared: 1/27/2014 3:35 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	60.00	LABORATORY	LAB	1,118,202	1,072,981 1.00
2.00	1.00	NEW CAP REL COSTS-BLDG & FIX	HOME OFFICE	990,334	0 2.00
3.00	9.00	HOUSEKEEPING	HOME OFFICE	64,994	0 3.00
4.00	5.01	NONPATIENT TELEPHONES	HOME OFFICE	35,643	0 4.00
4.01	50.00	OPERATING ROOM	HOME OFFICE	9,324	0 4.01
4.02	51.00	RECOVERY ROOM	HOME OFFICE	232	0 4.02
4.03	54.00	RADIOLOGY-DIAGNOSTIC	HOME OFFICE	55,405	0 4.03
4.04	66.00	PHYSICAL THERAPY	HOME OFFICE	28,108	0 4.04
4.05	67.00	OCCUPATIONAL THERAPY	HOME OFFICE	9,827	0 4.05
4.06	68.00	SPEECH PATHOLOGY	HOME OFFICE	1,842	0 4.06
4.07	69.00	ELECTROCARDIOLOGY	HOME OFFICE	8,049	0 4.07
4.08	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	29,768	0 4.08
4.09	7.00	OPERATION OF PLANT	HOME OFFICE	260,933	0 4.09
4.10	10.00	DIETARY	HOME OFFICE	4,661	0 4.10
4.11	11.00	CAFETERIA	HOME OFFICE	13,802	0 4.11
4.12	5.03	PURCHASING RECEIVING AND STO	HOME OFFICE	81,661	0 4.12
4.13	5.02	DATA PROCESSING	HOME OFFICE	1,315,744	0 4.13
4.14	13.00	NURSING ADMINISTRATION	HOME OFFICE	68,341	0 4.14
4.15	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	1,345,313	0 4.15
4.16	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	15,686	0 4.16
4.17	5.05	CASHIERING/ACCOUNTS RECEIVAB	HOME OFFICE	477,840	0 4.17
4.18	5.06	OTHER ADMINISTRATIVE AND GEN	HOME OFFICE	1,038,946	0 4.18
4.19	0.00			0	0 4.19
5.00	0		0	6,974,655	1,072,981 5.00

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

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

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

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

6.00	G		0.00	TH MEDICAL LAB	0.00	6.00
7.00	G		0.00	UNION HOSPITAL	0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	OTHER				100.00

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

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

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

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet A-8-1

Date/Time Prepared:
1/27/2014 3:35 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	45,221	0		1.00
2.00	990,334	9		2.00
3.00	64,994	0		3.00
4.00	35,643	0		4.00
4.01	9,324	0		4.01
4.02	232	0		4.02
4.03	55,405	0		4.03
4.04	28,108	0		4.04
4.05	9,827	0		4.05
4.06	1,842	0		4.06
4.07	8,049	0		4.07
4.08	29,768	0		4.08
4.09	260,933	0		4.09
4.10	4,661	0		4.10
4.11	13,802	0		4.11
4.12	81,661	0		4.12
4.13	1,315,744	0		4.13
4.14	68,341	0		4.14
4.15	1,345,313	0		4.15
4.16	15,686	0		4.16
4.17	477,840	0		4.17
4.18	1,038,946	0		4.18
4.19	0	0		4.19
5.00	5,901,674			5.00

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

Related Organization(s) and/or Home Office	Type of Business		
	6.00		
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:			

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

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

6.00	LAB		6.00
7.00	HOME OFFICE		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet A-8-2

Date/Time Prepared:
1/27/2014 3:35 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	30.00	ADULTS & PEDIATRICS	237,973	219,953	18,020	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	648,317	648,317	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	7,774	6,934	840	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			894,064	875,204	18,860	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	219,953	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	648,317	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	6,934	3.00
4.00	0.00		0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	875,204	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet B
Part I
Date/Time Prepared:
1/27/2014 3:35 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	1,608,328	1,608,328			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	442,513		442,513		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,345,313	0	0	1,345,313	4.00
5.01 00510	NONPATIENT TELEPHONES	64,816	1,704	19,239	0	85,759 5.01
5.02 00511	DATA PROCESSING	1,761,100	3,327	142,325	0	1,314 5.02
5.03 00512	PURCHASING RECEIVING AND STORES	84,395	12,963	317	0	657 5.03
5.04 00513	ADMINISTRATIVE	556,051	8,259	225	65,787	1,971 5.04
5.05 00514	CASHIERING/ACCOUNTS RECEIVABLE	960,420	4,884	0	3,035	1,643 5.05
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	2,032,136	24,156	13,200	88,580	4,929 5.06
7.00 00700	OPERATION OF PLANT	1,174,577	354,534	13,844	51,341	6,900 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,834	6,785	385	0	0 8.00
9.00 00900	HOUSEKEEPING	390,336	6,424	2,733	33,319	329 9.00
10.00 01000	DIETARY	175,026	73,155	14,445	13,279	2,300 10.00
11.00 01100	CAFETERIA	221,773	0	0	28,966	0 11.00
13.00 01300	NURSING ADMINISTRATION	761,673	22,648	2,979	79,718	1,314 13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	292,773	14,339	318	26,903	2,957 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,676,908	229,232	21,154	202,424	23,989 30.00
31.00 03100	INTENSIVE CARE UNIT	766,306	6,719	59,136	92,851	1,971 31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	645,719	48,917	41,205	47,062	2,300 50.00
51.00 05100	RECOVERY ROOM	70,565	4,933	1,752	9,090	657 51.00
51.01 05101	O/P TREATMENT ROOM	166,688	26,352	3,944	19,469	3,614 51.01
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,658,163	95,786	33,059	190,926	4,600 54.00
56.00 05600	RADIOISOTOPE	123,753	4,310	0	0	329 56.00
60.00 06000	LABORATORY	1,118,202	28,039	0	0	1,643 60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	119,488	0	0	0	0 62.00
65.00 06500	RESPIRATORY THERAPY	438,546	9,898	18,579	45,232	1,971 65.00
66.00 06600	PHYSICAL THERAPY	373,574	55,374	15,294	41,168	3,614 66.00
67.00 06700	OCCUPATIONAL THERAPY	129,815	46,574	274	14,378	2,629 67.00
68.00 06800	SPEECH PATHOLOGY	20,668	6,293	0	1,819	657 68.00
69.00 06900	ELECTROCARDIOLOGY	179,428	6,866	6,662	16,265	1,314 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	93,842	16,650	0	0	329 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	18,914	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,208,335	16,617	790	55,256	1,971 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	9,651	1,311	0	1,143	0 90.00
91.00 09100	EMERGENCY	1,563,316	137,821	29,877	174,198	9,857 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	22,254,945	1,274,870	441,736	1,302,209	85,759 118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	PHYSICIAN PRACTICES	555,468	56,112	777	43,104	0 194.00
194.01 07951	MEDICAL OFFICE BUILDING	0	148,473	0	0	0 194.01
194.02 07952	VPCHC	0	128,873	0	0	0 194.02
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)	22,810,413	1,608,328	442,513	1,345,313	85,759 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet B
Part I
Date/Time Prepared:
1/27/2014 3:35 pm

Cost Center Description		DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
		5.02	5.03	5.04	5.05	5A.05	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	NONPATIENT TELEPHONES					5.01
5.02	00511	DATA PROCESSING	1,908,066				5.02
5.03	00512	PURCHASING RECEIVING AND STORES	0	98,332			5.03
5.04	00513	ADMINITTING	90,860	204	723,357		5.04
5.05	00514	CASHIERING/ACCOUNTS RECEIVABLE	30,287	0	0	1,000,269	5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	196,864	55	0	0	2,359,920
7.00	00700	OPERATION OF PLANT	393,729	16	0	0	1,994,941
8.00	00800	LAUNDRY & LINEN SERVICE	0	435	0	0	9,439
9.00	00900	HOUSEKEEPING	15,143	6,998	0	0	455,282
10.00	01000	DIETARY	45,430	13	0	0	323,648
11.00	01100	CAFETERIA	0	0	0	0	250,739
13.00	01300	NURSING ADMINISTRATION	60,574	6	0	0	928,912
16.00	01600	MEDICAL RECORDS & LIBRARY	121,147	3	0	0	458,440
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	166,577	19,116	38,130	52,729	2,430,259
31.00	03100	INTENSIVE CARE UNIT	15,143	6,330	12,775	17,667	978,898
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	60,574	30,511	48,755	67,421	992,464
51.00	05100	RECOVERY ROOM	0	2,683	1,288	1,782	92,750
51.01	05101	O/P TREATMENT ROOM	15,143	0	9,062	12,531	256,803
54.00	05400	RADIOLOGY-DIAGNOSTIC	136,290	7,973	192,372	265,991	2,585,160
56.00	05600	RADIOISOTOPE	0	72	7,571	10,470	146,505
60.00	06000	LABORATORY	15,143	0	109,050	150,800	1,422,877
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	973	1,345	121,806
65.00	06500	RESPIRATORY THERAPY	30,287	2,400	11,527	15,940	574,380
66.00	06600	PHYSICAL THERAPY	60,574	285	15,193	21,010	586,086
67.00	06700	OCCUPATIONAL THERAPY	0	0	5,312	7,346	206,328
68.00	06800	SPEECH PATHOLOGY	0	0	996	1,378	31,811
69.00	06900	ELECTROCARDIOLOGY	0	85	25,014	34,591	270,225
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	76	1,419	1,962	114,278
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	219	303	19,436
73.00	07300	DRUGS CHARGED TO PATIENTS	45,430	353	77,827	107,623	1,514,202
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	56	78	12,239
91.00	09100	EMERGENCY	166,577	20,189	159,979	221,228	2,483,042
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,665,772	97,803	717,518	992,195	21,620,870
NONREIMBURSABLE COST CENTERS							
194.00	07950	PHYSICIAN PRACTICES	242,294	529	5,839	8,074	912,197
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	148,473
194.02	07952	VPCHC	0	0	0	0	128,873
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,908,066	98,332	723,357	1,000,269	22,810,413

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet B
Part I
Date/Time Prepared:
1/27/2014 3:35 pm

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL 5.06	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	NONPATIENT TELEPHONES					5.01
5.02	00511	DATA PROCESSING					5.02
5.03	00512	PURCHASING RECEIVING AND STORES					5.03
5.04	00513	ADMINITTING					5.04
5.05	00514	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	2,359,920				5.06
7.00	00700	OPERATION OF PLANT	230,210	2,225,151			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,089	14,114	24,642		8.00
9.00	00900	HOUSEKEEPING	52,538	13,364	1,766	522,950	9.00
10.00	01000	DIETARY	37,348	152,184	3	36,213	549,396
11.00	01100	CAFETERIA	28,935	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	107,194	47,114	1	11,211	0
16.00	01600	MEDICAL RECORDS & LIBRARY	52,903	29,830	1	7,098	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	280,445	476,872	4,825	113,476	446,770
31.00	03100	INTENSIVE CARE UNIT	112,962	13,978	1,598	3,326	81,636
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	114,527	101,763	7,703	24,215	0
51.00	05100	RECOVERY ROOM	10,703	10,262	0	2,442	0
51.01	05101	O/P TREATMENT ROOM	29,634	54,819	677	13,045	20,990
54.00	05400	RADIOLOGY-DIAGNOSTIC	298,313	199,265	2,013	47,416	0
56.00	05600	RADIOISOTOPE	16,906	8,966	18	2,134	0
60.00	06000	LABORATORY	164,196	58,331	0	13,880	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	14,056	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	66,282	20,591	606	4,900	0
66.00	06600	PHYSICAL THERAPY	67,633	115,195	72	27,411	0
67.00	06700	OCCUPATIONAL THERAPY	23,810	96,888	0	23,055	0
68.00	06800	SPEECH PATHOLOGY	3,671	13,091	0	3,115	0
69.00	06900	ELECTROCARDIOLOGY	31,183	14,284	21	3,399	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,187	34,637	19	8,242	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,243	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	174,734	34,569	89	8,226	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,412	2,727	0	649	0
91.00	09100	EMERGENCY	286,536	286,709	5,096	68,224	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,222,650	1,799,553	24,508	421,677	549,396
NONREIMBURSABLE COST CENTERS							
194.00	07950	PHYSICIAN PRACTICES	105,265	116,729	134	27,776	0
194.01	07951	MEDICAL OFFICE BUILDING	17,133	308,869	0	73,497	0
194.02	07952	VPCHC	14,872	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	2,359,920	2,225,151	24,642	522,950	549,396

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet B
Part I
Date/Time Prepared:
1/27/2014 3:35 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		11.00	13.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00511						5.02
5.03	00512						5.03
5.04	00513						5.04
5.05	00514						5.05
5.06	00560						5.06
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	279,674					11.00
13.00	01300	17,397	1,111,829				13.00
16.00	01600	13,660	0	561,932			16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	69,022	501,052	29,862	4,352,583	0	30.00
31.00	03100	24,408	177,511	10,005	1,404,322	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	13,454	97,878	38,182	1,390,186	0	50.00
51.00	05100	2,526	18,300	1,009	137,992	0	51.00
51.01	05101	4,949	0	7,097	388,014	0	51.01
54.00	05400	31,960	0	150,665	3,314,792	0	54.00
56.00	05600	0	0	5,929	180,458	0	56.00
60.00	06000	0	0	85,402	1,744,686	0	60.00
62.00	06200	0	0	762	136,624	0	62.00
65.00	06500	12,449	90,490	9,027	778,725	0	65.00
66.00	06600	12,243	89,012	11,899	909,551	0	66.00
67.00	06700	3,557	25,877	4,160	383,675	0	67.00
68.00	06800	619	4,559	780	57,646	0	68.00
69.00	06900	3,866	6,343	19,590	348,911	0	69.00
71.00	07100	0	0	1,111	171,474	0	71.00
72.00	07200	0	0	171	21,850	0	72.00
73.00	07300	13,480	98,032	60,950	1,904,282	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	387	2,775	44	20,233	0	90.00
91.00	09100	47,527	0	125,287	3,302,421	0	91.00
92.00	09200					0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		271,504	1,111,829	561,932	20,948,425	0	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	8,170	0	0	1,170,271	0	194.00
194.01	07951	0	0	0	547,972	0	194.01
194.02	07952	0	0	0	143,745	0	194.02
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		279,674	1,111,829	561,932	22,810,413	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet B
Part I
Date/Time Prepared:
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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
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00510 NONPATIENT TELEPHONES		5.01
5.02	00511 DATA PROCESSING		5.02
5.03	00512 PURCHASING RECEIVING AND STORES		5.03
5.04	00513 ADMIN TTING		5.04
5.05	00514 CASHIERING/ACCOUNTS RECEIVABLE		5.05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL		5.06
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	4,352,583	30.00
31.00	03100 INTENSIVE CARE UNIT	1,404,322	31.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	1,390,186	50.00
51.00	05100 RECOVERY ROOM	137,992	51.00
51.01	05101 O/P TREATMENT ROOM	388,014	51.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,314,792	54.00
56.00	05600 RADIOISOTOPE	180,458	56.00
60.00	06000 LABORATORY	1,744,686	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	136,624	62.00
65.00	06500 RESPIRATORY THERAPY	778,725	65.00
66.00	06600 PHYSICAL THERAPY	909,551	66.00
67.00	06700 OCCUPATIONAL THERAPY	383,675	67.00
68.00	06800 SPEECH PATHOLOGY	57,646	68.00
69.00	06900 ELECTROCARDIOLOGY	348,911	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	171,474	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	21,850	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,904,282	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	20,233	90.00
91.00	09100 EMERGENCY	3,302,421	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	20,948,425	118.00
NONREIMBURSABLE COST CENTERS			
194.00	07950 PHYSICIAN PRACTICES	1,170,271	194.00
194.01	07951 MEDICAL OFFICE BUILDING	547,972	194.01
194.02	07952 VPCHC	143,745	194.02
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	22,810,413	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet B
Part II
Date/Time Prepared:
1/27/2014 3:35 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.01 00510	NONPATIENT TELEPHONES	0	1,704	19,239	20,943	5.01
5.02 00511	DATA PROCESSING	0	3,327	142,325	145,652	5.02
5.03 00512	PURCHASING RECEIVING AND STORES	0	12,963	317	13,280	5.03
5.04 00513	ADMITTING	0	8,259	225	8,484	5.04
5.05 00514	CASHIERING/ACCOUNTS RECEIVABLE	0	4,884	0	4,884	5.05
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	0	24,156	13,200	37,356	5.06
7.00 00700	OPERATION OF PLANT	0	354,534	13,844	368,378	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	6,785	385	7,170	8.00
9.00 00900	HOUSEKEEPING	0	6,424	2,733	9,157	9.00
10.00 01000	DIETARY	0	73,155	14,445	87,600	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	22,648	2,979	25,627	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	14,339	318	14,657	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	229,232	21,154	250,386	30.00
31.00 03100	INTENSIVE CARE UNIT	0	6,719	59,136	65,855	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	48,917	41,205	90,122	50.00
51.00 05100	RECOVERY ROOM	0	4,933	1,752	6,685	51.00
51.01 05101	O/P TREATMENT ROOM	0	26,352	3,944	30,296	51.01
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	95,786	33,059	128,845	54.00
56.00 05600	RADIOISOTOPE	0	4,310	0	4,310	56.00
60.00 06000	LABORATORY	0	28,039	0	28,039	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
65.00 06500	RESPIRATORY THERAPY	0	9,898	18,579	28,477	65.00
66.00 06600	PHYSICAL THERAPY	0	55,374	15,294	70,668	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	46,574	274	46,848	67.00
68.00 06800	SPEECH PATHOLOGY	0	6,293	0	6,293	68.00
69.00 06900	ELECTROCARDIOLOGY	0	6,866	6,662	13,528	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	16,650	0	16,650	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	16,617	790	17,407	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	1,311	0	1,311	90.00
91.00 09100	EMERGENCY	0	137,821	29,877	167,698	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,274,870	441,736	1,716,606	118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	PHYSICIAN PRACTICES	0	56,112	777	56,889	194.00
194.01 07951	MEDICAL OFFICE BUILDING	0	148,473	0	148,473	194.01
194.02 07952	VPCHC	0	128,873	0	128,873	194.02
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,608,328	442,513	2,050,841	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINING	CASHIERING/ACCOUNTS RECEIVABLE	
		5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510	20,943					5.01
5.02	00511	321	145,973				5.02
5.03	00512	160	0	13,440			5.03
5.04	00513	481	6,951	28	15,944		5.04
5.05	00514	401	2,317	0	0	7,602	5.05
5.06	00560	1,204	15,061	8	0	0	5.06
7.00	00700	1,685	30,118	2	0	0	7.00
8.00	00800	0	0	60	0	0	8.00
9.00	00900	80	1,159	956	0	0	9.00
10.00	01000	562	3,476	2	0	0	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	321	4,634	1	0	0	13.00
16.00	01600	722	9,268	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	5,861	12,744	2,613	841	402	30.00
31.00	03100	481	1,159	865	282	135	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	562	4,634	4,170	1,076	514	50.00
51.00	05100	160	0	367	28	14	51.00
51.01	05101	883	1,159	0	200	95	51.01
54.00	05400	1,123	10,427	1,090	4,230	2,007	54.00
56.00	05600	80	0	10	167	80	56.00
60.00	06000	401	1,159	0	2,406	1,149	60.00
62.00	06200	0	0	0	21	10	62.00
65.00	06500	481	2,317	328	254	121	65.00
66.00	06600	883	4,634	39	335	160	66.00
67.00	06700	642	0	0	117	56	67.00
68.00	06800	160	0	0	22	10	68.00
69.00	06900	321	0	12	552	264	69.00
71.00	07100	80	0	10	31	15	71.00
72.00	07200	0	0	0	5	2	72.00
73.00	07300	481	3,476	48	1,717	820	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	1	1	90.00
91.00	09100	2,407	12,744	2,759	3,530	1,685	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		20,943	127,437	13,368	15,815	7,540	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	18,536	72	129	62	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		20,943	145,973	13,440	15,944	7,602	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.06	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	NONPATIENT TELEPHONES					5.01
5.02	00511	DATA PROCESSING					5.02
5.03	00512	PURCHASING RECEIVING AND STORES					5.03
5.04	00513	ADMITTING					5.04
5.05	00514	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	53,629				5.06
7.00	00700	OPERATION OF PLANT	5,231	405,414			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	25	2,571	9,826		8.00
9.00	00900	HOUSEKEEPING	1,194	2,435	704	15,685	9.00
10.00	01000	DIETARY	849	27,727	1	1,086	121,303
11.00	01100	CAFETERIA	657	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	2,436	8,584	1	336	0
16.00	01600	MEDICAL RECORDS & LIBRARY	1,202	5,435	0	213	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,372	86,882	1,924	3,407	98,643
31.00	03100	INTENSIVE CARE UNIT	2,567	2,547	637	100	18,025
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,602	18,541	3,070	726	0
51.00	05100	RECOVERY ROOM	243	1,870	0	73	0
51.01	05101	O/P TREATMENT ROOM	673	9,988	270	391	4,635
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,785	36,305	803	1,422	0
56.00	05600	RADIOISOTOPE	384	1,634	7	64	0
60.00	06000	LABORATORY	3,731	10,628	0	416	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	319	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,506	3,752	242	147	0
66.00	06600	PHYSICAL THERAPY	1,537	20,988	29	822	0
67.00	06700	OCCUPATIONAL THERAPY	541	17,653	0	691	0
68.00	06800	SPEECH PATHOLOGY	83	2,385	0	93	0
69.00	06900	ELECTROCARDIOLOGY	709	2,603	9	102	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	300	6,311	8	247	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	3,970	6,298	36	247	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	32	497	0	19	0
91.00	09100	EMERGENCY	6,511	52,237	2,032	2,046	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	50,510	327,871	9,773	12,648	121,303
NONREIMBURSABLE COST CENTERS							
194.00	07950	PHYSICIAN PRACTICES	2,392	21,268	53	833	0
194.01	07951	MEDICAL OFFICE BUILDING	389	56,275	0	2,204	0
194.02	07952	VPCHC	338	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	53,629	405,414	9,826	15,685	121,303

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		11.00	13.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00511						5.02
5.03	00512						5.03
5.04	00513						5.04
5.05	00514						5.05
5.06	00560						5.06
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	657					11.00
13.00	01300	41	41,981				13.00
16.00	01600	32	0	31,529			16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	162	18,917	1,676	490,830	0	30.00
31.00	03100	57	6,703	562	99,975	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	32	3,696	2,143	131,888	0	50.00
51.00	05100	6	691	57	10,194	0	51.00
51.01	05101	12	0	398	49,000	0	51.01
54.00	05400	75	0	8,447	201,559	0	54.00
56.00	05600	0	0	333	7,069	0	56.00
60.00	06000	0	0	4,793	52,722	0	60.00
62.00	06200	0	0	43	393	0	62.00
65.00	06500	29	3,417	507	41,578	0	65.00
66.00	06600	29	3,361	668	104,153	0	66.00
67.00	06700	8	977	233	67,766	0	67.00
68.00	06800	1	172	44	9,263	0	68.00
69.00	06900	9	240	1,099	19,448	0	69.00
71.00	07100	0	0	62	23,714	0	71.00
72.00	07200	0	0	10	68	0	72.00
73.00	07300	32	3,702	3,421	41,655	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	1	105	2	1,969	0	90.00
91.00	09100	112	0	7,031	260,792	0	91.00
92.00	09200					0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		638	41,981	31,529	1,614,036	0	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	19	0	0	100,253	0	194.00
194.01	07951	0	0	0	207,341	0	194.01
194.02	07952	0	0	0	129,211	0	194.02
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		657	41,981	31,529	2,050,841	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet B
Part II
Date/Time Prepared:
1/27/2014 3:35 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00510 NONPATIENT TELEPHONES		5.01
5.02	00511 DATA PROCESSING		5.02
5.03	00512 PURCHASING RECEIVING AND STORES		5.03
5.04	00513 ADMITTING		5.04
5.05	00514 CASHIERING/ACCOUNTS RECEIVABLE		5.05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL		5.06
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	490,830	30.00
31.00	03100 INTENSIVE CARE UNIT	99,975	31.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	131,888	50.00
51.00	05100 RECOVERY ROOM	10,194	51.00
51.01	05101 O/P TREATMENT ROOM	49,000	51.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	201,559	54.00
56.00	05600 RADIOISOTOPE	7,069	56.00
60.00	06000 LABORATORY	52,722	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	393	62.00
65.00	06500 RESPIRATORY THERAPY	41,578	65.00
66.00	06600 PHYSICAL THERAPY	104,153	66.00
67.00	06700 OCCUPATIONAL THERAPY	67,766	67.00
68.00	06800 SPEECH PATHOLOGY	9,263	68.00
69.00	06900 ELECTROCARDIOLOGY	19,448	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	23,714	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	68	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	41,655	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	1,969	90.00
91.00	09100 EMERGENCY	260,792	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,614,036	118.00
NONREIMBURSABLE COST CENTERS			
194.00	07950 PHYSICIAN PRACTICES	100,253	194.00
194.01	07951 MEDICAL OFFICE BUILDING	207,341	194.01
194.02	07952 VPCHC	129,211	194.02
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	2,050,841	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet B-1
Date/Time Prepared:
1/27/2014 3:35 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (PHONES)	DATA PROCESSING (DEVICES)	
	NEW BLDG & FIXT (SQ FT)	NEW MVBLE EQUIP (EQUIP DEPRN)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	98,142				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		440,328			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	9,698,183		4.00
5.01 00510	NONPATIENT TELEPHONES	104	19,144	0	261	5.01
5.02 00511	DATA PROCESSING	203	141,622	0	4	1,260
5.03 00512	PURCHASING RECEIVING AND STORES	791	315	0	2	0
5.04 00513	ADMINISTRATIVE	504	224	474,252	6	60
5.05 00514	CASHIERING/ACCOUNTS RECEIVABLE	298	0	21,878	5	20
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	1,474	13,135	638,562	15	130
7.00 00700	OPERATION OF PLANT	21,634	13,776	370,110	21	260
8.00 00800	LAUNDRY & LINEN SERVICE	414	383	0	0	0
9.00 00900	HOUSEKEEPING	392	2,720	240,194	1	10
10.00 01000	DIETARY	4,464	14,374	95,725	7	30
11.00 01100	CAFETERIA	0	0	208,809	0	0
13.00 01300	NURSING ADMINISTRATION	1,382	2,964	574,678	4	40
16.00 01600	MEDICAL RECORDS & LIBRARY	875	316	193,938	9	80
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	13,988	21,050	1,459,239	73	110
31.00 03100	INTENSIVE CARE UNIT	410	58,844	669,352	6	10
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	2,985	41,002	339,267	7	40
51.00 05100	RECOVERY ROOM	301	1,743	65,531	2	0
51.01 05101	O/P TREATMENT ROOM	1,608	3,925	140,352	11	10
54.00 05400	RADIOLOGY-DIAGNOSTIC	5,845	32,896	1,376,361	14	90
56.00 05600	RADIOISOTOPE	263	0	0	1	0
60.00 06000	LABORATORY	1,711	0	0	5	10
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	604	18,487	326,068	6	20
66.00 06600	PHYSICAL THERAPY	3,379	15,218	296,775	11	40
67.00 06700	OCCUPATIONAL THERAPY	2,842	273	103,650	8	0
68.00 06800	SPEECH PATHOLOGY	384	0	13,114	2	0
69.00 06900	ELECTROCARDIOLOGY	419	6,629	117,253	4	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,016	0	0	1	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	1,014	786	398,336	6	30
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	80	0	8,238	0	0
91.00 09100	EMERGENCY	8,410	29,729	1,255,768	30	110
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	77,794	439,555	9,387,450	261	1,100
NONREIMBURSABLE COST CENTERS						
194.00 07950	PHYSICIAN PRACTICES	3,424	773	310,733	0	160
194.01 07951	MEDICAL OFFICE BUILDING	9,060	0	0	0	0
194.02 07952	VPCHC	7,864	0	0	0	0
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,608,328	442,513	1,345,313	85,759	1,908,066
203.00	Unit cost multiplier (Wkst. B, Part I)	16.387765	1.004962	0.138718	328.578544	1,514.338095
204.00	Cost to be allocated (per Wkst. B, Part II)			0	20,943	145,973
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000	80.241379	115.851587

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet B-1

Date/Time Prepared:
1/27/2014 3:35 pm

Cost Center Description		PURCHASING RECEIVING AND STORES (REQUISITION)	ADMITTING (TOTAL REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (TOTAL REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
		5.03	5.04	5.05	5A.06	5.06	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00510 NONPATIENT TELEPHONES						5.01
5.02	00511 DATA PROCESSING						5.02
5.03	00512 PURCHASING RECEIVING AND STORES	414,135					5.03
5.04	00513 ADMITTING	858	65,685,904				5.04
5.05	00514 CASHIERING/ACCOUNTS RECEIVABLE	0	0	65,685,904			5.05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL	232	0	0	-2,359,920	20,450,493	5.06
7.00	00700 OPERATION OF PLANT	68	0	0	0	1,994,941	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1,834	0	0	0	9,439	8.00
9.00	00900 HOUSEKEEPING	29,471	0	0	0	455,282	9.00
10.00	01000 DIETARY	53	0	0	0	323,648	10.00
11.00	01100 CAFETERIA	0	0	0	0	250,739	11.00
13.00	01300 NURSING ADMINISTRATION	25	0	0	0	928,912	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	13	0	0	0	458,440	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	80,509	3,462,625	3,462,625	0	2,430,259	30.00
31.00	03100 INTENSIVE CARE UNIT	26,658	1,160,141	1,160,141	0	978,898	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	128,502	4,427,452	4,427,452	0	992,464	50.00
51.00	05100 RECOVERY ROOM	11,300	117,000	117,000	0	92,750	51.00
51.01	05101 O/P TREATMENT ROOM	0	822,891	822,891	0	256,803	51.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	33,580	17,467,112	17,467,112	0	2,585,160	54.00
56.00	05600 RADIOISOTOPE	304	687,552	687,552	0	146,505	56.00
60.00	06000 LABORATORY	0	9,902,788	9,902,788	0	1,422,877	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	88,332	88,332	0	121,806	62.00
65.00	06500 RESPIRATORY THERAPY	10,107	1,046,729	1,046,729	0	574,380	65.00
66.00	06600 PHYSICAL THERAPY	1,201	1,379,722	1,379,722	0	586,086	66.00
67.00	06700 OCCUPATIONAL THERAPY	2	482,371	482,371	0	206,328	67.00
68.00	06800 SPEECH PATHOLOGY	0	90,459	90,459	0	31,811	68.00
69.00	06900 ELECTROCARDIOLOGY	357	2,271,567	2,271,567	0	270,225	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	318	128,828	128,828	0	114,278	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	19,872	19,872	0	19,436	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,488	7,067,454	7,067,454	0	1,514,202	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	5,112	5,112	0	12,239	90.00
91.00	09100 EMERGENCY	85,027	14,527,698	14,527,698	0	2,483,042	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	411,907	65,155,705	65,155,705	-2,359,920	19,260,950	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950 PHYSICIAN PRACTICES	2,228	530,199	530,199	0	912,197	194.00
194.01	07951 MEDICAL OFFICE BUILDING	0	0	0	0	148,473	194.01
194.02	07952 VPCHC	0	0	0	0	128,873	194.02
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)	98,332	723,357	1,000,269		2,359,920	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.237439	0.011012	0.015228		0.115397	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	13,440	15,944	7,602		53,629	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.032453	0.000243	0.000116		0.002622	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet B-1

Date/Time Prepared:
1/27/2014 3:35 pm

Cost Center Description		OPERATION OF PLANT (SQ FT)	LAUNDRY & LINEN SERVICE (LINEN)	HOUSEKEEPING (NUMBER HOUSED)	DIETARY (DIETARY)	CAFETERIA (FTE)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00510 NONPATIENT TELEPHONES						5.01
5.02	00511 DATA PROCESSING						5.02
5.03	00512 PURCHASING RECEIVING AND STORES						5.03
5.04	00513 ADMITTING						5.04
5.05	00514 CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL						5.06
7.00	00700 OPERATION OF PLANT	65,270					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	414	411,143				8.00
9.00	00900 HOUSEKEEPING	392	29,471	64,464			9.00
10.00	01000 DIETARY	4,464	53	4,464	8,742		10.00
11.00	01100 CAFETERIA	0	0	0	0	10,851	11.00
13.00	01300 NURSING ADMINISTRATION	1,382	25	1,382	0	675	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	875	13	875	0	530	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	13,988	80,509	13,988	7,109	2,678	30.00
31.00	03100 INTENSIVE CARE UNIT	410	26,658	410	1,299	947	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,985	128,502	2,985	0	522	50.00
51.00	05100 RECOVERY ROOM	301	0	301	0	98	51.00
51.01	05101 O/P TREATMENT ROOM	1,608	11,300	1,608	334	192	51.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,845	33,580	5,845	0	1,240	54.00
56.00	05600 RADIOISOTOPE	263	304	263	0	0	56.00
60.00	06000 LABORATORY	1,711	0	1,711	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	604	10,107	604	0	483	65.00
66.00	06600 PHYSICAL THERAPY	3,379	1,201	3,379	0	475	66.00
67.00	06700 OCCUPATIONAL THERAPY	2,842	2	2,842	0	138	67.00
68.00	06800 SPEECH PATHOLOGY	384	0	384	0	24	68.00
69.00	06900 ELECTROCARDIOLOGY	419	357	419	0	150	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,016	318	1,016	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,014	1,488	1,014	0	523	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	80	0	80	0	15	90.00
91.00	09100 EMERGENCY	8,410	85,027	8,410	0	1,844	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	52,786	408,915	51,980	8,742	10,534	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950 PHYSICIAN PRACTICES	3,424	2,228	3,424	0	317	194.00
194.01	07951 MEDICAL OFFICE BUILDING	9,060	0	9,060	0	0	194.01
194.02	07952 VPCHC	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,225,151	24,642	522,950	549,396	279,674	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	34.091482	0.059935	8.112280	62.845573	25.774030	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	405,414	9,826	15,685	121,303	657	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	6.211338	0.023899	0.243314	13.875887	0.060547	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet B-1
Date/Time Prepared:
1/27/2014 3:35 pm

Cost Center Description		NURSING ADMINISTRATION (TIME SPENT) 13.00	MEDICAL RECORDS & LIBRARY (ASSIGNED TIME) 16.00	
GENERAL SERVICE COST CENTERS				
1.00	00100			1.00
2.00	00200			2.00
4.00	00400			4.00
5.01	00510			5.01
5.02	00511			5.02
5.03	00512			5.03
5.04	00513			5.04
5.05	00514			5.05
5.06	00560			5.06
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	123,396		13.00
16.00	01600	0	65,155,705	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	55,609	3,462,625	30.00
31.00	03100	19,701	1,160,141	31.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	10,863	4,427,452	50.00
51.00	05100	2,031	117,000	51.00
51.01	05101	0	822,891	51.01
54.00	05400	0	17,467,112	54.00
56.00	05600	0	687,552	56.00
60.00	06000	0	9,902,788	60.00
62.00	06200	0	88,332	62.00
65.00	06500	10,043	1,046,729	65.00
66.00	06600	9,879	1,379,722	66.00
67.00	06700	2,872	482,371	67.00
68.00	06800	506	90,459	68.00
69.00	06900	704	2,271,567	69.00
71.00	07100	0	128,828	71.00
72.00	07200	0	19,872	72.00
73.00	07300	10,880	7,067,454	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	308	5,112	90.00
91.00	09100	0	14,527,698	91.00
92.00	09200			92.00
SPECIAL PURPOSE COST CENTERS				
118.00		123,396	65,155,705	118.00
NONREIMBURSABLE COST CENTERS				
194.00	07950	0	0	194.00
194.01	07951	0	0	194.01
194.02	07952	0	0	194.02
200.00				200.00
201.00				201.00
202.00		1,111,829	561,932	202.00
203.00		9.010252	0.008624	203.00
204.00		41,981	31,529	204.00
205.00		0.340214	0.000484	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provi der CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet C
Part I
Date/Time Prepared:
1/27/2014 3:35 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	4,352,583		4,352,583	0	4,352,583	30.00
31.00	03100 INTENSIVE CARE UNIT	1,404,322		1,404,322	0	1,404,322	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,390,186		1,390,186	0	1,390,186	50.00
51.00	05100 RECOVERY ROOM	137,992		137,992	0	137,992	51.00
51.01	05101 O/P TREATMENT ROOM	388,014		388,014	0	388,014	51.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,314,792		3,314,792	0	3,314,792	54.00
56.00	05600 RADIOISOTOPE	180,458		180,458	0	180,458	56.00
60.00	06000 LABORATORY	1,744,686		1,744,686	0	1,744,686	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	136,624		136,624	0	136,624	62.00
65.00	06500 RESPIRATORY THERAPY	778,725	0	778,725	0	778,725	65.00
66.00	06600 PHYSICAL THERAPY	909,551	0	909,551	0	909,551	66.00
67.00	06700 OCCUPATIONAL THERAPY	383,675	0	383,675	0	383,675	67.00
68.00	06800 SPEECH PATHOLOGY	57,646	0	57,646	0	57,646	68.00
69.00	06900 ELECTROCARDIOLOGY	348,911		348,911	0	348,911	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	171,474		171,474	0	171,474	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	21,850		21,850	0	21,850	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,904,282		1,904,282	0	1,904,282	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	20,233		20,233	0	20,233	90.00
91.00	09100 EMERGENCY	3,302,421		3,302,421	0	3,302,421	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,219,903		1,219,903		1,219,903	92.00
200.00	Subtotal (see instructions)	22,168,328	0	22,168,328	0	22,168,328	200.00
201.00	Less Observation Beds	1,219,903		1,219,903		1,219,903	201.00
202.00	Total (see instructions)	20,948,425	0	20,948,425	0	20,948,425	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet C
Part I
Date/Time Prepared:
1/27/2014 3:35 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	3,462,625		3,462,625		30.00
31.00	03100	INTENSIVE CARE UNIT	1,160,141		1,160,141		31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,334,137	3,093,315	4,427,452	0.313992	50.00
51.00	05100	RECOVERY ROOM	25,560	91,440	117,000	1.179419	51.00
51.01	05101	O/P TREATMENT ROOM	4,482	818,409	822,891	0.471525	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,575,620	15,891,492	17,467,112	0.189773	54.00
56.00	05600	RADIOISOTOPE	27,437	660,115	687,552	0.262465	56.00
60.00	06000	LABORATORY	1,974,362	7,928,426	9,902,788	0.176181	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	61,559	26,773	88,332	1.546710	62.00
65.00	06500	RESPIRATORY THERAPY	739,555	307,174	1,046,729	0.743960	65.00
66.00	06600	PHYSICAL THERAPY	133,067	1,246,655	1,379,722	0.659228	66.00
67.00	06700	OCCUPATIONAL THERAPY	58,189	424,182	482,371	0.795394	67.00
68.00	06800	SPEECH PATHOLOGY	14,489	75,970	90,459	0.637261	68.00
69.00	06900	ELECTROCARDIOLOGY	532,320	1,739,247	2,271,567	0.153599	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	103,276	25,552	128,828	1.331031	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,443	18,429	19,872	1.099537	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,155,610	3,911,844	7,067,454	0.269444	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	5,112	5,112	3.957942	90.00
91.00	09100	EMERGENCY	651,818	13,875,880	14,527,698	0.227319	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	94,997	1,449,509	1,544,506	0.789834	92.00
200.00		Subtotal (see instructions)	15,110,687	51,589,524	66,700,211		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	15,110,687	51,589,524	66,700,211		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet C
Part I
Date/Time Prepared:
1/27/2014 3:35 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
51.01	05101 O/P TREATMENT ROOM	0.000000			51.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	05600 RADIOISOTOPE	0.000000			56.00
60.00	06000 LABORATORY	0.000000			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provi der CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet C
Part I
Date/Time Prepared:
1/27/2014 3:35 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	4,352,583		4,352,583	0	4,352,583	30.00
31.00	03100 INTENSIVE CARE UNIT	1,404,322		1,404,322	0	1,404,322	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,390,186		1,390,186	0	1,390,186	50.00
51.00	05100 RECOVERY ROOM	137,992		137,992	0	137,992	51.00
51.01	05101 O/P TREATMENT ROOM	388,014		388,014	0	388,014	51.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,314,792		3,314,792	0	3,314,792	54.00
56.00	05600 RADIOISOTOPE	180,458		180,458	0	180,458	56.00
60.00	06000 LABORATORY	1,744,686		1,744,686	0	1,744,686	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	136,624		136,624	0	136,624	62.00
65.00	06500 RESPIRATORY THERAPY	778,725	0	778,725	0	778,725	65.00
66.00	06600 PHYSICAL THERAPY	909,551	0	909,551	0	909,551	66.00
67.00	06700 OCCUPATIONAL THERAPY	383,675	0	383,675	0	383,675	67.00
68.00	06800 SPEECH PATHOLOGY	57,646	0	57,646	0	57,646	68.00
69.00	06900 ELECTROCARDIOLOGY	348,911		348,911	0	348,911	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	171,474		171,474	0	171,474	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	21,850		21,850	0	21,850	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,904,282		1,904,282	0	1,904,282	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	20,233		20,233	0	20,233	90.00
91.00	09100 EMERGENCY	3,302,421		3,302,421	0	3,302,421	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,219,903		1,219,903		1,219,903	92.00
200.00	Subtotal (see instructions)	22,168,328	0	22,168,328	0	22,168,328	200.00
201.00	Less Observation Beds	1,219,903		1,219,903		1,219,903	201.00
202.00	Total (see instructions)	20,948,425	0	20,948,425	0	20,948,425	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet C
Part I
Date/Time Prepared:
1/27/2014 3:35 pm

		Title XIX			Hospital	Cost		
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,462,625		3,462,625			30.00
31.00	03100	INTENSIVE CARE UNIT	1,160,141		1,160,141			31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,334,137	3,093,315	4,427,452	0.313992	0.000000	50.00
51.00	05100	RECOVERY ROOM	25,560	91,440	117,000	1.179419	0.000000	51.00
51.01	05101	O/P TREATMENT ROOM	4,482	818,409	822,891	0.471525	0.000000	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,575,620	15,891,492	17,467,112	0.189773	0.000000	54.00
56.00	05600	RADIOISOTOPE	27,437	660,115	687,552	0.262465	0.000000	56.00
60.00	06000	LABORATORY	1,974,362	7,928,426	9,902,788	0.176181	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	61,559	26,773	88,332	1.546710	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	739,555	307,174	1,046,729	0.743960	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	133,067	1,246,655	1,379,722	0.659228	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	58,189	424,182	482,371	0.795394	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	14,489	75,970	90,459	0.637261	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	532,320	1,739,247	2,271,567	0.153599	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	103,276	25,552	128,828	1.331031	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,443	18,429	19,872	1.099537	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,155,610	3,911,844	7,067,454	0.269444	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	5,112	5,112	3.957942	0.000000	90.00
91.00	09100	EMERGENCY	651,818	13,875,880	14,527,698	0.227319	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	94,997	1,449,509	1,544,506	0.789834	0.000000	92.00
200.00		Subtotal (see instructions)	15,110,687	51,589,524	66,700,211			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	15,110,687	51,589,524	66,700,211			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provi der CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet C
Part I
Date/Time Prepared:
1/27/2014 3:35 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
51.01	05101 O/P TREATMENT ROOM	0.000000			51.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	05600 RADIOISOTOPE	0.000000			56.00
60.00	06000 LABORATORY	0.000000			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151326	Period: From 09/01/2012 To 08/31/2013	Worksheet D Part II Date/Time Prepared: 1/27/2014 3:35 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	131,888	4,427,452	0.029789	505,637	15,062	50.00
51.00	05100 RECOVERY ROOM	10,194	117,000	0.087128	9,360	816	51.00
51.01	05101 O/P TREATMENT ROOM	49,000	822,891	0.059546	2,693	160	51.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	201,559	17,467,112	0.011539	570,493	6,583	54.00
56.00	05600 RADIOISOTOPE	7,069	687,552	0.010281	12,445	128	56.00
60.00	06000 LABORATORY	52,722	9,902,788	0.005324	1,030,152	5,485	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	393	88,332	0.004449	45,010	200	62.00
65.00	06500 RESPIRATORY THERAPY	41,578	1,046,729	0.039722	329,602	13,092	65.00
66.00	06600 PHYSICAL THERAPY	104,153	1,379,722	0.075488	75,825	5,724	66.00
67.00	06700 OCCUPATIONAL THERAPY	67,766	482,371	0.140485	34,147	4,797	67.00
68.00	06800 SPEECH PATHOLOGY	9,263	90,459	0.102400	12,096	1,239	68.00
69.00	06900 ELECTROCARDIOLOGY	19,448	2,271,567	0.008561	338,472	2,898	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	23,714	128,828	0.184075	52,933	9,744	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	68	19,872	0.003422	1,443	5	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	41,655	7,067,454	0.005894	1,815,460	10,700	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	1,969	5,112	0.385172	0	0	90.00
91.00	09100 EMERGENCY	260,792	14,527,698	0.017951	9,085	163	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,544,506	0.000000	0	0	92.00
200.00	Total (lines 50-199)	1,023,231	62,077,445		4,844,853	76,796	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151326	Period: From 09/01/2012 To 08/31/2013	Worksheet D Part IV Date/Time Prepared: 1/27/2014 3:35 pm
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Cost Center Description		Title XVIII				Hospital		Total Cost (sum of col 1 through col. 4)
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	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
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet D
Part IV
Date/Time Prepared:
1/27/2014 3:35 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital			
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	4,427,452	0.000000	0.000000	505,637	50.00
51.00	05100	RECOVERY ROOM	0	117,000	0.000000	0.000000	9,360	51.00
51.01	05101	O/P TREATMENT ROOM	0	822,891	0.000000	0.000000	2,693	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,467,112	0.000000	0.000000	570,493	54.00
56.00	05600	RADIOISOTOPE	0	687,552	0.000000	0.000000	12,445	56.00
60.00	06000	LABORATORY	0	9,902,788	0.000000	0.000000	1,030,152	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	88,332	0.000000	0.000000	45,010	62.00
65.00	06500	RESPIRATORY THERAPY	0	1,046,729	0.000000	0.000000	329,602	65.00
66.00	06600	PHYSICAL THERAPY	0	1,379,722	0.000000	0.000000	75,825	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	482,371	0.000000	0.000000	34,147	67.00
68.00	06800	SPEECH PATHOLOGY	0	90,459	0.000000	0.000000	12,096	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,271,567	0.000000	0.000000	338,472	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	128,828	0.000000	0.000000	52,933	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	19,872	0.000000	0.000000	1,443	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,067,454	0.000000	0.000000	1,815,460	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	5,112	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	14,527,698	0.000000	0.000000	9,085	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,544,506	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	62,077,445			4,844,853	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet D
Part IV
Date/Time Prepared:
1/27/2014 3:35 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
51.01	05101 O/P TREATMENT ROOM	0	0	0		51.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600 RADIOISOTOPE	0	0	0		56.00
60.00	06000 LABORATORY	0	0	0		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet D
Part V
Date/Time Prepared:
1/27/2014 3:35 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	0.313992	0	978,136	0	0	50.00
51.00	05100 RECOVERY ROOM	1.179419	0	28,200	0	0	51.00
51.01	05101 O/P TREATMENT ROOM	0.471525	0	263,135	0	0	51.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.189773	0	4,513,873	0	0	54.00
56.00	05600 RADIOISOTOPE	0.262465	0	223,631	0	0	56.00
60.00	06000 LABORATORY	0.176181	0	2,947,848	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1.546710	0	17,098	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.743960	0	180,366	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.659228	0	448,928	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.795394	0	114,111	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.637261	0	13,874	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.153599	0	707,248	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.331031	0	11,171	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1.099537	0	8,679	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.269444	0	1,912,014	6,511	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	3.957942	0	3,548	0	0	90.00
91.00	09100 EMERGENCY	0.227319	0	3,484,861	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.789834	0	695,040	0	0	92.00
200.00	Subtotal (see instructions)		0	16,551,761	6,511	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	16,551,761	6,511		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151326	Period: From 09/01/2012 To 08/31/2013	Worksheet D Part V Date/Time Prepared: 1/27/2014 3:35 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	307,127	0		50.00
51.00 05100 RECOVERY ROOM	33,260	0		51.00
51.01 05101 O/P TREATMENT ROOM	124,075	0		51.01
54.00 05400 RADIOLOGY-DIAGNOSTIC	856,611	0		54.00
56.00 05600 RADIOISOTOPE	58,695	0		56.00
60.00 06000 LABORATORY	519,355	0		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	26,446	0		62.00
65.00 06500 RESPIRATORY THERAPY	134,185	0		65.00
66.00 06600 PHYSICAL THERAPY	295,946	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	90,763	0		67.00
68.00 06800 SPEECH PATHOLOGY	8,841	0		68.00
69.00 06900 ELECTROCARDIOLOGY	108,633	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14,869	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	9,543	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	515,181	1,754		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	14,043	0		90.00
91.00 09100 EMERGENCY	792,175	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	548,966	0		92.00
200.00 Subtotal (see instructions)	4,458,714	1,754		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	4,458,714	1,754		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151326	Period: From 09/01/2012 To 08/31/2013	Worksheet D Part V Date/Time Prepared: 1/27/2014 3:35 pm
		Component CCN: 15Z326	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	0.313992	0	0	0	50.00
51.00	05100 RECOVERY ROOM	1.179419	0	0	0	51.00
51.01	05101 O/P TREATMENT ROOM	0.471525	0	0	0	51.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.189773	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0.262465	0	0	0	56.00
60.00	06000 LABORATORY	0.176181	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1.546710	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.743960	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.659228	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.795394	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.637261	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.153599	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.331031	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1.099537	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.269444	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	3.957942	0	0	0	90.00
91.00	09100 EMERGENCY	0.227319	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.789834	0	0	0	92.00
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: 151326 Component CCN: 15Z326	Period: From 09/01/2012 To 08/31/2013	Worksheet D Part V Date/Time Prepared: 1/27/2014 3:35 pm
	Title XVIIII	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
51.01	05101	O/P TREATMENT ROOM	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151326	Period: From 09/01/2012 To 08/31/2013	Worksheet D-1 Date/Time Prepared: 1/27/2014 3:35 pm
Cost Center Description		Title XVIII	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,520	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,304	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,323	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		37	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)		157	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		22	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,459	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)		37	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)		157	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		123.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		123.32	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,352,583	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)		2,713	25.00
26.00	Total swing-bed cost (see instructions)		243,958	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,108,625	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,108,625	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)		1,243.53	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,814,310	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)		1,814,310	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151326		Period: From 09/01/2012 To 08/31/2013		Worksheet D-1	
Date/Time Prepared: 1/27/2014 3:35 pm		Title XVIII		Hospital		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)							42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	1,404,322	464	3,026.56	285	862,570		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,479,041		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,155,921		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)					46,011		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					195,234		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					241,245		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)						981	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,243.53		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						1,219,903	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151326		Period: From 09/01/2012 To 08/31/2013		Worksheet D-1 Date/Time Prepared: 1/27/2014 3:35 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: 151326	Period: From 09/01/2012 To 08/31/2013	Worksheet D-1
		Title XIX		Date/Time Prepared: 1/27/2014 3:35 pm
		Hospital		Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,520	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,304	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,323	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		194	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		22	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		330	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)		4,352,583	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)		241,396	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,111,187	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,111,187	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)		1,244.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		410,622	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)		410,622	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151326		Period: From 09/01/2012 To 08/31/2013		Worksheet D-1	
Date/Time Prepared: 1/27/2014 3:35 pm		Title XIX		Hospital		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)							42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	1,404,322	464	3,026.56	43	130,142		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)					309,782		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					850,546		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)						981	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,244.31	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						1,220,668	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151326		Period: From 09/01/2012 To 08/31/2013		Worksheet D-1 Date/Time Prepared: 1/27/2014 3:35 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: 151326	Period: From 09/01/2012 To 08/31/2013	Worksheet D-3 Date/Time Prepared: 1/27/2014 3:35 pm	
Cost Center Description		Title XVIII	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		2,081,345	30.00
31.00	03100	INTENSIVE CARE UNIT		711,180	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.313992	505,637	158,766 50.00
51.00	05100	RECOVERY ROOM	1.179419	9,360	11,039 51.00
51.01	05101	O/P TREATMENT ROOM	0.471525	2,693	1,270 51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.189773	570,493	108,264 54.00
56.00	05600	RADIOISOTOPE	0.262465	12,445	3,266 56.00
60.00	06000	LABORATORY	0.176181	1,030,152	181,493 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1.546710	45,010	69,617 62.00
65.00	06500	RESPIRATORY THERAPY	0.743960	329,602	245,211 65.00
66.00	06600	PHYSICAL THERAPY	0.659228	75,825	49,986 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.795394	34,147	27,160 67.00
68.00	06800	SPEECH PATHOLOGY	0.637261	12,096	7,708 68.00
69.00	06900	ELECTROCARDIOLOGY	0.153599	338,472	51,989 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.331031	52,933	70,455 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.099537	1,443	1,587 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.269444	1,815,460	489,165 73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	3.957942	0	0 90.00
91.00	09100	EMERGENCY	0.227319	9,085	2,065 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.789834	0	0 92.00
200.00		Total (sum of lines 50-94 and 96-98)		4,844,853	1,479,041 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		4,844,853	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151326	Period: From 09/01/2012 To 08/31/2013	Worksheet D-3	
		Component CCN: 15Z326		Date/Time Prepared: 1/27/2014 3:35 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		130,550	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.313992	1,390	436 50.00
51.00	05100	RECOVERY ROOM	1.179419	0	0 51.00
51.01	05101	O/P TREATMENT ROOM	0.471525	0	0 51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.189773	1,830	347 54.00
56.00	05600	RADIOISOTOPE	0.262465	0	0 56.00
60.00	06000	LABORATORY	0.176181	27,861	4,909 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1.546710	0	0 62.00
65.00	06500	RESPIRATORY THERAPY	0.743960	22,462	16,711 65.00
66.00	06600	PHYSICAL THERAPY	0.659228	29,199	19,249 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.795394	15,501	12,329 67.00
68.00	06800	SPEECH PATHOLOGY	0.637261	428	273 68.00
69.00	06900	ELECTROCARDIOLOGY	0.153599	1,150	177 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.331031	2,333	3,105 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.099537	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.269444	96,912	26,112 73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	3.957942	0	0 90.00
91.00	09100	EMERGENCY	0.227319	177	40 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.789834	0	0 92.00
200.00		Total (sum of lines 50-94 and 96-98)		199,243	83,688 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		199,243	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151326	Period: From 09/01/2012 To 08/31/2013	Worksheet D-3 Date/Time Prepared: 1/27/2014 3:35 pm	
Cost Center Description		Title XIX	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		319,721	30.00
31.00	03100	INTENSIVE CARE UNIT		82,645	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.313992	200,872	63,072 50.00
51.00	05100	RECOVERY ROOM	1.179419	3,600	4,246 51.00
51.01	05101	O/P TREATMENT ROOM	0.471525	0	0 51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.189773	234,418	44,486 54.00
56.00	05600	RADIOISOTOPE	0.262465	4,851	1,273 56.00
60.00	06000	LABORATORY	0.176181	279,562	49,254 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1.546710	3,898	6,029 62.00
65.00	06500	RESPIRATORY THERAPY	0.743960	83,278	61,956 65.00
66.00	06600	PHYSICAL THERAPY	0.659228	6,560	4,325 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.795394	1,990	1,583 67.00
68.00	06800	SPEECH PATHOLOGY	0.637261	681	434 68.00
69.00	06900	ELECTROCARDIOLOGY	0.153599	56,082	8,614 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.331031	6,909	9,196 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.099537	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.269444	0	0 73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	3.957942	0	0 90.00
91.00	09100	EMERGENCY	0.227319	243,334	55,314 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.789834	0	0 92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,126,035	309,782 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		1,126,035	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151326	Period: From 09/01/2012	Worksheet D-3	
		Component CCN: 15Z326	To 08/31/2013	Date/Time Prepared: 1/27/2014 3:35 pm	
		Title XIX	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.313992	0	0 50.00
51.00	05100	RECOVERY ROOM	1.179419	0	0 51.00
51.01	05101	O/P TREATMENT ROOM	0.471525	0	0 51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.189773	0	0 54.00
56.00	05600	RADIOISOTOPE	0.262465	0	0 56.00
60.00	06000	LABORATORY	0.176181	0	0 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1.546710	0	0 62.00
65.00	06500	RESPIRATORY THERAPY	0.743960	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.659228	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.795394	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.637261	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.153599	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.331031	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.099537	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.269444	0	0 73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	3.957942	0	0 90.00
91.00	09100	EMERGENCY	0.227319	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.789834	0	0 92.00
200.00		Total (sum of lines 50-94 and 96-98)		0	0 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		0	0 202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 151326	Peri od: From 09/01/2012 To 08/31/2013	Worksheet E Part B Date/Time Prepared: 1/27/2014 3: 35 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			4,460,468 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			4,460,468 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)			4,505,073 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)			31,760 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,700,838 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			1,772,475 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			1,772,475 30.00
31.00	Primary payer payments			1,367 31.00
32.00	Subtotal (line 30 minus line 31)			1,771,108 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)			635,845 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			635,845 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			442,651 36.00
37.00	Subtotal (see instructions)			2,406,953 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			2,406,953 40.00
40.01	Sequestration adjustment (see instructions)			20,218 40.01
41.00	Interim payments			2,153,407 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			233,328 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: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet E-1
Part I
Date/Time Prepared:
1/27/2014 3:35 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		3,480,119		1,692,969	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	09/01/2012	86,095	09/01/2012	460,438	3.01	
3.02		03/26/2013	198,500		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)		284,595		460,438	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,764,714		2,153,407	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		8,579		233,328	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		3,773,293		2,386,735	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: 151326
Component CCN: 15Z326

Period:
From 09/01/2012
To 08/31/2013

Worksheet E-1
Part I
Date/Time Prepared:
1/27/2014 3:35 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		298,475		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)		298,475		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		24,910		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		323,385		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: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet E-1
Part II
Date/Time Prepared:
1/27/2014 3:35 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			999 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			1,744 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			0 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			2,787 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			66,700,211 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			3,642,680 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			440,683 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			379,825 8.00
9.00	Sequestration adjustment amount (see instructions)			0 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			379,825 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			356,168 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)			23,657 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 151326	Period: From 09/01/2012 To 08/31/2013	Worksheet E-2
		Component CCN: 15Z326		Date/Time Prepared: 1/27/2014 3:35 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)		243,657	0
2.00	Inpatient routine services - swing bed-NF (see instructions)			0
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)		84,525	0
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00
5.00	Program days		194	0
6.00	Interns and residents not in approved teaching program (see instructions)			0
7.00	Utilization review - physician compensation - SNF optional method only		0	0
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		328,182	0
9.00	Primary payer payments (see instructions)		0	0
10.00	Subtotal (line 8 minus line 9)		328,182	0
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0
12.00	Subtotal (line 10 minus line 11)		328,182	0
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)		2,058	0
14.00	80% of Part B costs (line 12 x 80%)			0
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		326,124	0
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
17.00	Allowable bad debts (see instructions)		0	0
17.01	Adjusted reimbursable bad debts (see instructions)		0	0
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0
19.00	Total (see instructions)		326,124	0
19.01	Sequestration adjustment (see instructions)		2,739	0
20.00	Interim payments		298,475	0
21.00	Tentative settlement (for contractor use only)		0	0
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21		24,910	0
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	0

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

		Provider CCN: 151326	Period: From 09/01/2012 To 08/31/2013	Worksheet E-2
		Component CCN: 15Z326		Date/Time Prepared: 1/27/2014 3:35 pm
		Title XIX	Swing Beds - SNF	Cost
			Part A	Part B
			1.00	2.00
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)		0	2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)		0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days		0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	8.00
9.00	Primary payer payments (see instructions)		0	9.00
10.00	Subtotal (line 8 minus line 9)		0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	11.00
12.00	Subtotal (line 10 minus line 11)		0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	16.00
17.00	Allowable bad debts (see instructions)		0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	18.00
19.00	Total (see instructions)		0	19.00
19.01	Sequestration adjustment (see instructions)		0	19.01
20.00	Interim payments		0	20.00
21.00	Tentative settlement (for contractor use only)		0	21.00
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21		0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151326	Period: From 09/01/2012 To 08/31/2013	Worksheet E-3 Part V Date/Time Prepared: 1/27/2014 3:35 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			4,155,921 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)			4,155,921 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			4,197,480 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)			4,197,480 19.00
20.00	Deductibles (exclude professional component)			464,572 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			3,732,908 22.00
23.00	Coinsurance			1,480 23.00
24.00	Subtotal (line 22 minus line 23)			3,731,428 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			73,829 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			73,829 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			29,096 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			3,805,257 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)			3,805,257 30.00
30.01	Sequestration adjustment (see instructions)			31,964 30.01
31.00	Interim payments			3,764,714 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			8,579 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151326	Period: From 09/01/2012 To 08/31/2013	Worksheet E-3 Part VII Date/Time Prepared: 1/27/2014 3:35 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		850,546		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)		850,546	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)		850,546	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		402,366		8.00
9.00	Ancillary service charges		1,126,035	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		1,528,401	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		1,528,401	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		677,855	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)		850,546	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)		850,546	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)		850,546	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		850,546	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		850,546	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)		850,546	0	40.00
41.00	Interim payments		850,546	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		0		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0		43.00

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

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet G

Date/Time Prepared:
1/27/2014 3:35 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	4,406	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,100,197	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	284,896	0	0	0	7.00
8.00	Prepaid expenses	15,483,041	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	-2,004,219	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	16,868,321	0	0	0	11.00
FIXED ASSETS						
12.00	Land	559,748	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	10,460,280	0	0	0	15.00
16.00	Accumulated depreciation	-8,776,213	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	5,557,973	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	7,801,788	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	24,670,109	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	349,312	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,372,876	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	246,062	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,968,250	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	-20	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-20	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	1,968,230	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	22,701,879	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)	22,701,879	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	24,670,109	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet G-1

Date/Time Prepared:
1/27/2014 3:35 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		18,367,080		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		4,334,799			2.00
3.00	Total (sum of line 1 and line 2)		22,701,879		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)		22,701,879		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)		22,701,879		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: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet G-2
Parts I & II
Date/Time Prepared:
1/27/2014 3:35 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	4,920,107		4,920,107	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	145,500		145,500	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)	5,065,607		5,065,607	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	1,160,141		1,160,141	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	1,160,141		1,160,141	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,225,748		6,225,748	17.00
18.00	Ancillary services	9,928,782	37,880,854	47,809,636	18.00
19.00	Outpatient services	651,818	13,883,977	14,535,795	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PRACTICES	0	530,199	530,199	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	16,806,348	52,295,030	69,101,378	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		19,786,406		29.00
30.00	ALLOCATED	1,938,747			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)		1,938,747		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)		21,725,153		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151326

Period:
From 09/01/2012
To 08/31/2013

Worksheet G-3

Date/Time Prepared:
1/27/2014 3:35 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	69,101,378	1.00
2.00	Less contractual allowances and discounts on patients' accounts	39,891,470	2.00
3.00	Net patient revenues (line 1 minus line 2)	29,209,908	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	21,725,153	4.00
5.00	Net income from service to patients (line 3 minus line 4)	7,484,755	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 REVENUE	293,663	24.00
24.01	TOTAL NON-OPERATING REVENUES	25	24.01
24.02	BAD DEBT	-3,443,644	24.02
24.03		0	24.03
24.04		0	24.04
25.00	Total other income (sum of lines 6-24)	-3,149,956	25.00
26.00	Total (line 5 plus line 25)	4,334,799	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)	4,334,799	29.00