

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).
 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

FORM APPROVED
 OMB NO. 0938-0050
 Worksheet 5
 Parts I-III
 Date/Time Prepared:
 5/24/2014 10:26 am

Provider CCN: 153043
 Period:
 From 07/16/2013
 To 12/31/2013

PART I - COST REPORT STATUS

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

Contractor use only
 5. Cost Report Status
 (1) As Submitted
 (2) Settled without Audit
 (3) Settled with Audit
 (4) Reopened
 (5) Amended
 6. Date Received:
 7. Contractor No.
 8. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN
 10. NPR Date:
 11. Contractor's Vendor Code: 4
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 5/24/2014 Time: 10:26 am

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by INDIANAPOLIS REHAB HOSPITAL (153043) for the cost reporting period beginning 07/16/2013 and ending 12/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 5/24/2014 Time: 10:26 am
 .eJLEsSluRfQc1oACy40Xgq1dr0G0
 tx:vm0YRlRtce:Jws.51735A3bv2c4
 omBm0YoEqZ02vOm.
 PI: Date: 5/24/2014 Time: 10:26 am
 V:CGhAS3u3yb174vYvgX9Ao15YzQx0
 iehFX0bJne4rRIdmv7aaTV5pwAhuG
 cYQG0fsdz90899mf

(Signed)

 Officer or Administrator of Provider(s)

Title

Date

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	39,750	0	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
200.00 Total	0	39,750	0	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 153043	Period: From 07/16/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/24/2014 10:25 am
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1.00	2.00	3.00	4.00	1.00	2.00
Hospital and Hospital Health Care Complex Address:					
Street: 7343 CLEAR VISTA DRIVE		PO Box:			
City: INDIANAPOLIS		State: IN		Zip Code: 46256	
				County:	

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
						V	XVIII	XIX		
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	INDIANAPOLIS REHAB HOSPITAL	153043	26900	5	07/16/2013	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									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)	07/16/2013	12/31/2013	20.00
21.00	Type of Control (see instructions)	5		21.00

Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N				22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)									22.01
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					0				23.00

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	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.	171	0	0	0	0	0	25.00

	Urban/Rural S	Date of Geogr	
	1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1	26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1	27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0	35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 153043	Period: From 07/16/2013 To 12/31/2013	Worksheet S-2 Part 1 Date/Time Prepared: 5/24/2014 10:25 am		
		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.	N				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)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		
61.04	Enter the number of unweighted primary care and/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		
		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

Worksheet S-2
Part 1
Date/Time Prepared:
5/24/2014 10:25 am

		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	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings							
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00	
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00			
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010. Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

Worksheet S-2
Part I
Date/Time Prepared:
5/24/2014 10:25 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00
							1.00 2.00 3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N		70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				Y		75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				N	0	76.00
							1.00
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N	80.00
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00
							V XIX
							1.00 2.00
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.				N	N	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.				N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.				N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.				N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.					0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.				N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.					0.00	97.00
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?				N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)						106.00

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			V 1.00	XIX 2.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(C). Enter "Y" for yes or "N" for no.		N		108.00
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
				1.00	2.00 3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00	
118.01	List amounts of malpractice premiums and paid losses:	8,500	0		0
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPD 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	HB0158	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: CENTERRE HEALTHCARE CORPORATION	Contractor's Name: CAHABA GMA	Contractor's Number: 10101	141.00
142.00	Street: 5250 VIRGINIA WAY	PO Box:		142.00
143.00	City: BRENTWOOD	State: TN	Zip Code: 37027	143.00

144.00	Are provider based physicians' costs included in worksheet A?	1.00	N	144.00
145.00	If costs for renal services are claimed on worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	1.00	Y	145.00

146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	1.00	N	2.00	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

Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00

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

Health Information Technology (HIT) Incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 153043	Period: From 07/16/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/24/2014 10:25 am
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	Y/N	Date	
	1.00	2.00	

General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.

COMPLETED BY ALL HOSPITALS

Provider Organization and Operation

1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	

Financial Data and Reports

4.00	Column 1: were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	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.		N		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N		14.00

Bed Complement

15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N		15.00
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Description

Part A

Part B

	Y/N	Date	Y/N
0	1.00	2.00	3.00

PS&R Data

16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/13/2014	N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for other? Describe the other adjustments:	N		N	20.00

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	was the cost report prepared only using the provider's records? If yes, see instructions.	1.00	2.00	3.00	21.00
		N		N	
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			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.			N	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.	JONATHAN		UTTZ	41.00
42.00	Enter the employer/company name of the cost report preparer.	KRAFT HEALTHCARE CONSULTING			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-782-4298		JUTT2@KRAFTCPAS.COM	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		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.	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

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	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	50	8,450	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		50	8,450	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		50	8,450	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						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)		50				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	925	171	3,744			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	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	925	171	3,744			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)	925	171	3,744	0.00	79.32	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	79.32	27.00
28.00 Observation Bed Days		0	0			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

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	72	10	298	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	72	10	298	14.00	
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	86,270	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	571,183	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	0	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	231,497	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	67,444	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	1,509	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	957,903	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

Worksheet A
Date/Time Prepared:
5/24/2014 10:25 am

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (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 CAP REL COSTS-BLOG & FIXT		0	0	1,177,450	1,177,450	1.00	
2.00 00200 CAP REL COSTS-MVBLE EQUIP		0	0	271,422	271,422	2.00	
3.00 00300 OTHER CAP REL COSTS		0	0	0	0	3.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	1,690,594	1,690,594	4.00	
5.00 00500 ADMINISTRATIVE & GENERAL	936,294	3,525,905	4,462,199	-3,262,529	1,199,670	5.00	
7.00 00700 OPERATION OF PLANT	0	0	0	155,558	155,558	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	0	25,861	25,861	0	25,861	8.00	
9.00 00900 HOUSEKEEPING	54,979	16,933	71,912	0	71,912	9.00	
10.00 01000 DIETARY	159,227	107,017	266,244	-692	265,552	10.00	
13.00 01300 NURSING ADMINISTRATION	139,129	6,957	146,086	0	146,086	13.00	
15.00 01500 PHARMACY	0	284,619	284,619	-123,808	160,811	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	24,913	4,903	29,816	0	29,816	16.00	
17.00 01700 SOCIAL SERVICE	51,550	45,230	96,780	-2,021	94,759	17.00	
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	1,370,035	227,260	1,597,295	-27,638	1,569,657	30.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	27,314	27,314	0	27,314	54.00	
60.00 06000 LABORATORY	0	20,141	20,141	0	20,141	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00	
65.00 06500 RESPIRATORY THERAPY	24,137	46,371	70,508	0	70,508	65.00	
66.00 06600 PHYSICAL THERAPY	412,878	96,592	509,470	0	509,470	66.00	
67.00 06700 OCCUPATIONAL THERAPY	166,752	166,741	333,493	0	333,493	67.00	
68.00 06800 SPEECH PATHOLOGY	118,864	9,968	128,832	0	128,832	68.00	
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	99,509	99,509	-2,144	97,365	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	123,808	123,808	73.00	
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00	
OUTPATIENT SERVICE COST CENTERS							
91.00 09100 EMERGENCY	0	0	0	0	0	91.00	
SPECIAL PURPOSE COST CENTERS							
113.00 11300 INTEREST EXPENSE		0	0	0	0	113.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)					8,170,079	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00	
191.00 19100 RESEARCH	0	0	0	0	0	191.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00	
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00	
194.00 07951 MARKETING	222,536	12,591	235,127	0	235,127	194.00	
200.00	TOTAL (SUM OF LINES 118-199)					8,405,206	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

Worksheet A
Date/Time Prepared:
5/24/2014 10:25 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	-172,521	1,004,929	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-120,444	150,978	2.00
3.00	00300 OTHER CAP REL COSTS	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	1,690,594	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-1,113,457	86,213	5.00
7.00	00700 OPERATION OF PLANT	-52,485	103,073	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	-16,614	9,247	8.00
9.00	00900 HOUSEKEEPING	-76,172	-4,260	9.00
10.00	01000 DIETARY	-36,258	229,294	10.00
13.00	01300 NURSING ADMINISTRATION	0	146,086	13.00
15.00	01500 PHARMACY	0	160,811	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-457	29,359	16.00
17.00	01700 SOCIAL SERVICE	0	94,759	17.00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	0	1,569,657	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	27,314	54.00
60.00	06000 LABORATORY	0	20,141	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	70,508	65.00
66.00	06600 PHYSICAL THERAPY	0	509,470	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	333,493	67.00
68.00	06800 SPEECH PATHOLOGY	0	128,832	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	97,365	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	123,808	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0	0	91.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-1,588,408	6,581,671	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100 RESEARCH	0	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300 NONPAID WORKERS	0	0	193.00
194.00	07951 MARKETING	0	235,127	194.00
200.00	TOTAL (SUM OF LINES 118-199)	-1,588,408	6,816,798	200.00

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - RENTS AND LEASES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	958,663	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	31,097	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	989,760	
B - CAPITAL RELATED EXPENSES					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00		15,449	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00		85,676	2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00		130,000	3.00
4.00	CAP REL COSTS-BLDG & FIXT	1.00		3,111	4.00
5.00	CAP REL COSTS-MVBLE EQUIP	2.00		224,876	5.00
	TOTALS		0	459,112	
C - REPAIRS AND MAINTENANCE					
1.00	OPERATION OF PLANT	7.00	0	13,529	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	13,529	
D - UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	142,029	1.00
	TOTALS		0	142,029	
E - CHARGEABLE DRUGS AND SUPPLIES					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	123,808	1.00
	TOTALS		0	123,808	
F - BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,690,594	1.00
	TOTALS		0	1,690,594	
500.00	Grand Total: Increases		0	3,418,832	500.00

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - RENTS AND LEASES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	959,978	10		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	27,638	10		2.00
3.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,144	0		3.00
	TOTALS		0	989,760			
B - CAPITAL RELATED EXPENSES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	459,112	11		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	13		3.00
4.00		0.00	0	0	13		4.00
5.00		0.00	0	0	9		5.00
	TOTALS		0	459,112			
C - REPAIRS AND MAINTENANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	10,816	0		1.00
2.00	DIETARY	10.00	0	692	0		2.00
3.00	SOCIAL SERVICE	17.00	0	2,021	0		3.00
	TOTALS		0	13,529			
D - UTILITIES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	142,029	0		1.00
	TOTALS		0	142,029			
E - CHARGEABLE DRUGS AND SUPPLIES							
1.00	PHARMACY	15.00	0	123,808	0		1.00
	TOTALS		0	123,808			
F - BENEFITS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,690,594	0		1.00
	TOTALS		0	1,690,594			
500.00	Grand Total: Decreases		0	3,418,832			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

Worksheet A-7
Part 1
Date/Time Prepared:
5/24/2014 10:25 am

	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	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	6,733	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	2,314,281	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	2,321,014	0	0	0	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	2,321,014	0	0	0	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	6,733	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	2,314,281	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	2,321,014	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	2,321,014	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

Worksheet A-7
Part II
Date/Time Prepared:
5/24/2014 10:25 am

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

Worksheet A-7
Part III
Date/Time Prepared:
5/24/2014 10:25 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,441,809	0	2,441,809	1.000000	0	2.00
3.00	Total (sum of lines 1-2)	2,441,809	0	2,441,809	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	CAP REL COSTS-BLDG & FIXT	0	0	0	0	826,793	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	104,432	31,097	2.00
3.00	Total (sum of lines 1-2)	0	0	0	104,432	857,890	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	CAP REL COSTS-BLDG & FIXT	-40,651	85,676	133,111	0	1,004,929	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15,449	0	0	0	150,978	2.00
3.00	Total (sum of lines 1-2)	-25,202	85,676	133,111	0	1,155,907	3.00

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted			Ref.
				Cost Center	Line #	Wkst. A-7	
				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	0			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	43,065			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-13,722	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-457	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	B	-2,141	ADMINISTRATIVE & GENERAL	5.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00			0		0.00	0	33.00
33.01			0		0.00	0	33.01

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
33.02	A	-74,361	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	A	-51,231	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	A	-8,022	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	A	-131,870	CAP REL COSTS-BLDG & FIXT	1.00	10	33.05
33.06	A	-40,651	CAP REL COSTS-BLDG & FIXT	1.00	11	33.06
33.07	A	-155,684	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.07
33.08	A	-985,527	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	A	-52,485	OPERATION OF PLANT	7.00	0	33.09
33.10	A	-16,614	LAUNDRY & LINEN SERVICE	8.00	0	33.10
33.11	A	-76,172	HOUSEKEEPING	9.00	0	33.11
33.12	A	-22,536	DIETARY	10.00	0	33.12
33.13		0		0.00	0	33.13
33.14		0		0.00	0	33.14
33.15		0		0.00	0	33.15
33.16		0		0.00	0	33.16
33.17		0		0.00	0	33.17
33.18		0		0.00	0	33.18
33.19		0		0.00	0	33.19
33.20		0		0.00	0	33.20
33.21		0		0.00	0	33.21
33.22		0		0.00	0	33.22
33.23		0		0.00	0	33.23
33.24		0		0.00	0	33.24
33.25		0		0.00	0	33.25
33.26		0		0.00	0	33.26
33.27		0		0.00	0	33.27
33.28		0		0.00	0	33.28
33.29		0		0.00	0	33.29
50.00		-1,588,408				50.00
TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)						

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

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

Worksheet A-8-1

Date/Time Prepared:
5/24/2014 10:25 am

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	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	355,000 1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	ALLOWABLE HO CAPITAL	34,146	0 2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	ALLOWABLE HO OTHER	351,562	0 3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	ALLOWABLE HO START UP	1,094	0 4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	ALLOWABLE HO START UP	11,263	0 4.01
4.02	0.00			0	0 4.02
4.03	0.00			0	0 4.03
4.04	0.00			0	0 4.04
4.05	0.00			0	0 4.05
5.00	0			398,065	355,000 5.00

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

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

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

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

6.00	B	0.00	CENTERRE HEALTH	70.00	6.00
7.00		0.00		0.00	7.00
8.00		0.00		0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

Worksheet A-8-1
Date/Time Prepared:
5/24/2014 10:25 am

	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	-355,000	0	1.00
2.00	34,146	9	2.00
3.00	351,562	0	3.00
4.00	1,094	9	4.00
4.01	11,263	0	4.01
4.02	0	0	4.02
4.03	0	0	4.03
4.04	0	0	4.04
4.05	0	0	4.05
5.00	43,065		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	CORPORATION	6.00
7.00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

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

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

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,004,929	1,004,929			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	150,978		150,978		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,690,594	0	0	1,690,594	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	86,213	32,678	4,910	429,983	5.00
7.00 00700	OPERATION OF PLANT	103,073	33,286	5,001	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	9,247	11,713	1,760	0	8.00
9.00 00900	HOUSEKEEPING	-4,260	4,778	718	25,249	9.00
10.00 01000	DIETARY	229,294	64,973	9,761	73,123	10.00
13.00 01300	NURSING ADMINISTRATION	146,086	4,778	718	63,893	13.00
15.00 01500	PHARMACY	160,811	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	29,359	1,598	240	11,441	16.00
17.00 01700	SOCIAL SERVICE	94,759	0	0	23,674	17.00
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,569,657	730,703	109,779	629,173	3,039,312
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	27,314	0	0	0	27,314
60.00 06000	LABORATORY	20,141	975	146	0	21,262
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
65.00 06500	RESPIRATORY THERAPY	70,508	2,924	439	11,085	84,956
66.00 06600	PHYSICAL THERAPY	509,470	56,504	8,489	189,610	764,073
67.00 06700	OCCUPATIONAL THERAPY	333,493	23,186	3,483	76,579	436,741
68.00 06800	SPEECH PATHOLOGY	128,832	11,106	1,669	54,587	196,194
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	97,365	17,082	2,566	0	117,013
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	123,808	4,618	694	0	129,120
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	0	0	0	91.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	6,581,671	1,000,902	150,373	1,588,397	6,474,842
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07951	MARKETING	235,127	4,027	605	102,197	341,956
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	TOTAL (sum lines 118-201)	6,816,798	1,004,929	150,978	1,690,594	6,816,798

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

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Cost Center Description		ADMINISTRATIVE	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DIETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	553,784					5.00
7.00	00700	12,499	153,859				7.00
8.00	00800	2,009	1,919	26,648			8.00
9.00	00900	2,342	783	0	29,610		9.00
10.00	01000	33,348	10,647	0	2,086	423,232	10.00
13.00	01300	19,053	783	0	153	0	13.00
15.00	01500	14,219	0	0	0	0	15.00
16.00	01600	3,770	262	0	51	0	16.00
17.00	01700	10,472	0	0	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	268,741	119,732	17,594	23,456	423,232	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	0	50.00
54.00	05400	2,415	0	0	0	0	54.00
60.00	06000	1,880	160	0	31	0	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
65.00	06500	7,512	479	0	94	0	65.00
66.00	06600	67,560	9,259	4,525	1,814	0	66.00
67.00	06700	38,617	3,799	4,529	744	0	67.00
68.00	06800	17,348	1,820	0	356	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	10,346	2,799	0	548	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	11,417	757	0	148	0	73.00
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	0	0	0	0	91.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		523,548	153,199	26,648	29,481	423,232	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07951	30,236	660	0	129	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		553,784	153,859	26,648	29,610	423,232	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 153043

Period:
From 07/16/2013
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Cost Center Description		NURSING	PHARMACY	MEDICAL	SOCIAL SERVICE	OTHER GENERAL	
		ADMINISTRATION		RECORDS & LIBRARY		SERVICE (SPECIFY)	
		13.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
13.00	01300	235,464					13.00
15.00	01500	0	175,030				15.00
16.00	01600	0	0	46,721			16.00
17.00	01700	0	0	0	128,905		17.00
18.00	01850	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	235,464	0	46,721	128,905	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	0	50.00
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	0	0	0	0	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	175,030	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	0	0	0	0	91.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		235,464	175,030	46,721	128,905	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07951	0	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		235,464	175,030	46,721	128,905	0	202.00

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
13.00	01300	NURSING ADMINISTRATION			13.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)			18.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	4,303,157	0	4,303,157
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,729	0	29,729
60.00	06000	LABORATORY	23,333	0	23,333
60.01	06001	BLOOD LABORATORY	0	0	0
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0
65.00	06500	RESPIRATORY THERAPY	93,041	0	93,041
66.00	06600	PHYSICAL THERAPY	847,231	0	847,231
67.00	06700	OCCUPATIONAL THERAPY	484,430	0	484,430
68.00	06800	SPEECH PATHOLOGY	215,718	0	215,718
69.00	06900	ELECTROCARDIOLOGY	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	130,706	0	130,706
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	316,472	0	316,472
74.00	07400	RENAL DIALYSIS	0	0	0
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,443,817	0	6,443,817
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0
191.00	19100	RESEARCH	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0
194.00	07951	MARKETING	372,981	0	372,981
200.00		Cross Foot Adjustments	0	0	0
201.00		Negative Cost Centers	0	0	0
202.00		TOTAL (sum lines 118-201)	6,816,798	0	6,816,798

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	32,678	4,910	37,588	5.00
7.00 00700	OPERATION OF PLANT	0	33,286	5,001	38,287	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	11,713	1,760	13,473	8.00
9.00 00900	HOUSEKEEPING	0	4,778	718	5,496	9.00
10.00 01000	DIETARY	0	64,973	9,761	74,734	10.00
13.00 01300	NURSING ADMINISTRATION	0	4,778	718	5,496	13.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	1,598	240	1,838	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	730,703	109,779	840,482	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	0	975	146	1,121	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
65.00 06500	RESPIRATORY THERAPY	0	2,924	439	3,363	65.00
66.00 06600	PHYSICAL THERAPY	0	56,504	8,489	64,993	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	23,186	3,483	26,669	67.00
68.00 06800	SPEECH PATHOLOGY	0	11,106	1,669	12,775	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17,082	2,566	19,648	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	4,618	694	5,312	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	0	0	0	91.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,000,902	150,373	1,151,275	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07951	MARKETING	0	4,027	605	4,632	194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	TOTAL (sum lines 118-201)	0	1,004,929	150,978	1,155,907	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 153043

Period:
From 07/16/2013
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	37,588					5.00
7.00	00700	848	39,135				7.00
8.00	00800	136	488	14,097			8.00
9.00	00900	159	199	0	5,118		9.00
10.00	01000	2,264	2,708	0	360	80,066	10.00
13.00	01300	1,293	199	0	27	0	13.00
15.00	01500	965	0	0	0	0	15.00
16.00	01600	256	67	0	9	0	16.00
17.00	01700	711	0	0	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	18,240	30,455	9,307	4,054	80,066	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	0	50.00
54.00	05400	164	0	0	0	0	54.00
60.00	06000	128	41	0	5	0	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100						61.00
62.00	06200	0	0	0	0	0	62.00
65.00	06500	510	122	0	16	0	65.00
66.00	06600	4,586	2,355	2,394	313	0	66.00
67.00	06700	2,621	966	2,396	129	0	67.00
68.00	06800	1,178	463	0	62	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	702	712	0	95	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	775	192	0	26	0	73.00
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	0	0	0	0	91.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		35,536	38,967	14,097	5,096	80,066	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07951	2,052	168	0	22	0	194.00
200.00							200.00
201.00		0	0	0	736	0	201.00
202.00		37,588	39,135	14,097	5,854	80,066	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 153043

Period:
From 07/16/2013
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Cost Center Description	NURSING	PHARMACY	MEDICAL	SOCIAL SERVICE	OTHER GENERAL	
	ADMINISTRATION		RECORDS & LIBRARY		SERVICE (SPECIFY)	
	13.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLOG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
13.00 01300 NURSING ADMINISTRATION	7,015					13.00
15.00 01500 PHARMACY	0	965				15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	2,170			16.00
17.00 01700 SOCIAL SERVICE	0	0	0	711		17.00
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	7,015	0	2,170	711	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
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
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	965	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	7,015	965	2,170	711	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07951 MARKETING	0	0	0	0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	7,015	965	2,170	711	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

Worksheet B
Part II
Date/Time Prepared:
5/24/2014 10:25 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100 CAP REL COSTS-BLOG & FIXT				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500 ADMINISTRATIVE & GENERAL				5.00
7.00	00700 OPERATION OF PLANT				7.00
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00	00900 HOUSEKEEPING				9.00
10.00	01000 DIETARY				10.00
13.00	01300 NURSING ADMINISTRATION				13.00
15.00	01500 PHARMACY				15.00
16.00	01600 MEDICAL RECORDS & LIBRARY				16.00
17.00	01700 SOCIAL SERVICE				17.00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)				18.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	992,500	0	992,500	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	164	0	164	54.00
60.00	06000 LABORATORY	1,295	0	1,295	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	4,011	0	4,011	65.00
66.00	06600 PHYSICAL THERAPY	74,641	0	74,641	66.00
67.00	06700 OCCUPATIONAL THERAPY	32,781	0	32,781	67.00
68.00	06800 SPEECH PATHOLOGY	14,478	0	14,478	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	21,157	0	21,157	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7,270	0	7,270	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0	0	0	91.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,148,297	0	1,148,297	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
191.00	19100 RESEARCH	0	0	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
193.00	19300 NONPAID WORKERS	0	0	0	193.00
194.00	07951 MARKETING	6,874	0	6,874	194.00
200.00	Cross Foot Adjustments	0	0	0	200.00
201.00	Negative Cost Centers	736	0	736	201.00
202.00	TOTAL (sum lines 118-201)	1,155,907	0	1,155,907	202.00

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLOG & FIXT	62,888					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		62,888				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	3,681,294			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,045	2,045	936,294	-553,784	6,263,014	5.00
7.00 00700	OPERATION OF PLANT	2,083	2,083	0	0	141,360	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	733	733	0	0	22,720	8.00
9.00 00900	HOUSEKEEPING	299	299	54,979	0	26,485	9.00
10.00 01000	DIETARY	4,066	4,066	159,227	0	377,151	10.00
13.00 01300	NURSING ADMINISTRATION	299	299	139,129	0	215,475	13.00
15.00 01500	PHARMACY	0	0	0	0	160,811	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	100	100	24,913	0	42,638	16.00
17.00 01700	SOCIAL SERVICE	0	0	51,550	0	118,433	17.00
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	45,727	45,727	1,370,035	0	3,039,312	30.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	27,314	54.00
60.00 06000	LABORATORY	61	61	0	0	21,262	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00 06500	RESPIRATORY THERAPY	183	183	24,137	0	84,956	65.00
66.00 06600	PHYSICAL THERAPY	3,536	3,536	412,878	0	764,073	66.00
67.00 06700	OCCUPATIONAL THERAPY	1,451	1,451	166,752	0	436,741	67.00
68.00 06800	SPEECH PATHOLOGY	695	695	118,864	0	196,194	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,069	1,069	0	0	117,013	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	289	289	0	0	129,120	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
91.00 09100	EMERGENCY	0	0	0	0	0	91.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	62,636	62,636	3,458,758	-553,784	5,921,058	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07951	MARKETING	252	252	222,536	0	341,956	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per wkst. B, Part I)	1,004,929	150,978	1,690,594		553,784	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	15.979662	2.400744	0.459239		0.088421	203.00
204.00	Cost to be allocated (per wkst. B, Part II)			0		37,588	204.00
205.00	Unit cost multiplier (wkst. B, Part II)			0.000000		0.006002	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

Worksheet B-1

Date/Time Prepared:
5/24/2014 10:25 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (TOTAL PATIENT DAYS)	
		7.00	8.00	9.00	10.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800	58,760					8.00
9.00	00900	733	40,051				9.00
10.00	01000	299	0	57,728			10.00
13.00	01300	4,066	0	4,066	11,434		13.00
15.00	01500	299	0	299	0	3,744	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	100	0	100	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	45,727	26,443	45,727	11,434	3,744	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	0	50.00
54.00	05400	0	0	0	0	0	54.00
60.00	06000	61	0	61	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
65.00	06500	183	0	183	0	0	65.00
66.00	06600	3,536	6,801	3,536	0	0	66.00
67.00	06700	1,451	6,807	1,451	0	0	67.00
68.00	06800	695	0	695	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	1,069	0	1,069	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	289	0	289	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	0	0	0	0	91.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		58,508	40,051	57,476	11,434	3,744	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07951	252	0	252	0	0	194.00
200.00							200.00
201.00							201.00
202.00		153,859	26,648	29,610	423,232	235,464	202.00
203.00		2.618431	0.665352	0.512923	37.015218	62.891026	203.00
204.00		39,135	14,097	5,854	80,066	7,015	204.00
205.00		0.666014	0.351976	0.088657	7.002449	1.873665	205.00

Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TOTAL PATIENT DAYS)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY) (TIME SPENT)		
	15.00	16.00	17.00	18.00		
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLOG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
13.00 01300	NURSING ADMINISTRATION					13.00
15.00 01500	PHARMACY	123,808				15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	3,744			16.00
17.00 01700	SOCIAL SERVICE	0	0	3,744		17.00
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	3,744	3,744	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	0	0	0	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	123,808	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	0	0	0	91.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	123,808	3,744	3,744	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07951	MARKETING	0	0	0	0	194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per wkst. B, Part I)	175,030	46,721	128,905	0	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	1.413721	12.478900	34.429754	0.000000	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	965	2,170	711	0	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	0.007794	0.579594	0.189904	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

Worksheet C
Part I
Date/Time Prepared:
5/24/2014 10:25 am

Cost Center Description		Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII		Hospital		PPS
				Total Costs	RCE Disallowance	Total Costs	Total Costs	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,303,157		4,303,157	0	4,303,157	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0		0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,729		29,729	0	29,729	54.00
60.00	06000	LABORATORY	23,333		23,333	0	23,333	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	93,041	0	93,041	0	93,041	65.00
66.00	06600	PHYSICAL THERAPY	847,231	0	847,231	0	847,231	66.00
67.00	06700	OCCUPATIONAL THERAPY	484,430	0	484,430	0	484,430	67.00
68.00	06800	SPEECH PATHOLOGY	215,718	0	215,718	0	215,718	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	130,706		130,706	0	130,706	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	316,472		316,472	0	316,472	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0		0	0	0	91.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	6,443,817	0	6,443,817	0	6,443,817	200.00
201.00		Less Observation Beds	0		0	0	0	201.00
202.00		Total (see instructions)	6,443,817	0	6,443,817	0	6,443,817	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

Worksheet C
Part I
Date/Time Prepared:
5/24/2014 10:25 am

Cost Center Description	Title XVIII			Hospital	PPS	
	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,710,635			30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	125,123	0	0.237598	54.00
60.00	06000	LABORATORY	487,519	0	0.047861	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	47,692	0	1.950872	65.00
66.00	06600	PHYSICAL THERAPY	1,468,779	0	0.576827	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,470,039	0	0.329535	67.00
68.00	06800	SPEECH PATHOLOGY	818,677	0	0.263496	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,036	0	9.312197	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,349,183	0	0.234566	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0.000000	91.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	11,491,683	0	11,491,683	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	11,491,683	0	11,491,683	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

Worksheet C
Part 1
Date/Time Prepared:
5/24/2014 10:25 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.237598			54.00
60.00	06000 LABORATORY	0.047861			60.00
60.01	06001 BLOOD LABORATORY	0.000000			60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000			61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
65.00	06500 RESPIRATORY THERAPY	1.950872			65.00
66.00	06600 PHYSICAL THERAPY	0.576827			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.329535			67.00
68.00	06800 SPEECH PATHOLOGY	0.263496			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9.312197			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.234566			73.00
74.00	07400 RENAL DIALYSIS	0.000000			74.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.000000			91.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

Worksheet C
Part I
Date/Time Prepared:
5/24/2014 10:25 am

Cost Center Description	Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital		Total Costs	
			Total Costs	RCE Disallowance	Total Costs	Cost		
			1.00	2.00	3.00	4.00		5.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,303,157		4,303,157	0	4,303,157	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0		0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,729		29,729	0	29,729	54.00
60.00	06000	LABORATORY	23,333		23,333	0	23,333	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	93,041	0	93,041	0	93,041	65.00
66.00	06600	PHYSICAL THERAPY	847,231	0	847,231	0	847,231	66.00
67.00	06700	OCCUPATIONAL THERAPY	484,430	0	484,430	0	484,430	67.00
68.00	06800	SPEECH PATHOLOGY	215,718	0	215,718	0	215,718	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	130,706		130,706	0	130,706	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	316,472		316,472	0	316,472	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0		0	0	0	91.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	6,443,817	0	6,443,817	0	6,443,817	200.00
201.00		Less Observation Beds	0		0	0	0	201.00
202.00		Total (see instructions)	6,443,817	0	6,443,817	0	6,443,817	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

Worksheet C
Part I
Date/Time Prepared:
5/24/2014 10:25 am

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
Title XIX Hospital Cost						
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,710,635		5,710,635	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	125,123	0	125,123	54.00
60.00	06000	LABORATORY	487,519	0	487,519	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	47,692	0	47,692	65.00
66.00	06600	PHYSICAL THERAPY	1,468,779	0	1,468,779	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,470,039	0	1,470,039	67.00
68.00	06800	SPEECH PATHOLOGY	818,677	0	818,677	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,036	0	14,036	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,349,183	0	1,349,183	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	91.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	11,491,683	0	11,491,683	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	11,491,683	0	11,491,683	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

Worksheet C
Part I
Date/Time Prepared:
5/24/2014 10:25 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
30.00	03000 ADULTS & PEDIATRICS				30.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
60.01	06001 BLOOD LABORATORY	0.000000			60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000			61.00
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400 RENAL DIALYSIS	0.000000			74.00
	OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0.000000			91.00
	SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 153043		Period: From 07/16/2013 To 12/31/2013		Worksheet D Part I Date/Time Prepared: 5/24/2014 10:25 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	992,500	0	992,500	3,744	265.09	30.00
200.00	Total (lines 30-199)	992,500		992,500	3,744		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	925	245,208				
200.00	Total (lines 30-199)	925	245,208				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

Worksheet D
Part II
Date/Time Prepared:
5/24/2014 10:25 am

Cost Center Description	Title XVIII			Hospital	PPS		
	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	0	0	0.000000	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	164	125,123	0.001311	21,119	28 54.00
60.00	06000	LABORATORY	1,295	487,519	0.002656	126,042	335 60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0 60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY					
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0 62.00
65.00	06500	RESPIRATORY THERAPY	4,011	47,692	0.084102	12,822	1,078 65.00
66.00	06600	PHYSICAL THERAPY	74,641	1,468,779	0.050818	385,035	19,567 66.00
67.00	06700	OCCUPATIONAL THERAPY	32,781	1,470,039	0.022299	376,731	8,401 67.00
68.00	06800	SPEECH PATHOLOGY	14,478	818,677	0.017685	271,125	4,795 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,157	14,036	1.507338	6,097	9,190 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,270	1,349,183	0.005388	266,490	1,436 73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0 74.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0.000000	0	0 91.00
200.00		Total (lines 50-199)	155,797	5,781,048		1,465,461	44,830 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

Worksheet D
Part III
Date/Time Prepared:
5/24/2014 10:25 am

Cost Center Description		Title XVIII			Hospital	PPS	Total Costs (sum of cols. 1 through 3, minus col. 4)
		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
200.00		Total (lines 30-199)	0	0	0	0	200.00
Cost Center Description		Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
		6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,744	0.00	925	0	30.00
200.00		Total (lines 30-199)	3,744		925	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

Worksheet D
Part IV
Date/Time Prepared:
5/24/2014 10:25 am

Cost Center Description	Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
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: 153043

Period:
From 07/16/2013
To 12/31/2013

Worksheet D
Part IV
Date/Time Prepared:
5/24/2014 10:25 am

Cost Center Description		Title XVIII			Hospital		PPS	
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)	Outpatient Ratio of Cost to Charges (col. 6 + col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0.000000	0.000000	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	125,123	0.000000	0.000000	21,119	54.00
60.00	06000	LABORATORY	0	487,519	0.000000	0.000000	126,042	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0.000000	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0.000000	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	47,692	0.000000	0.000000	12,822	65.00
66.00	06600	PHYSICAL THERAPY	0	1,468,779	0.000000	0.000000	385,035	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,470,039	0.000000	0.000000	376,731	67.00
68.00	06800	SPEECH PATHOLOGY	0	818,677	0.000000	0.000000	271,125	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,036	0.000000	0.000000	6,097	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,349,183	0.000000	0.000000	266,490	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0.000000	0.000000	0	91.00
200.00		Total (lines 50-199)	0	5,781,048			1,465,461	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

Worksheet D
Part IV
Date/Time Prepared:
5/24/2014 10:25 am

Cost Center Description		Title XVIII			Hospital	PPS
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	61.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	91.00
200.00		Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

Worksheet D
Part V
Date/Time Prepared:
5/24/2014 10:25 am

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)	
			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		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237598	0	0	0	0	54.00
60.00	06000	LABORATORY	0.047861	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1.950872	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.576827	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.329535	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.263496	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9.312197	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.234566	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

Worksheet D
Part V
Date/Time Prepared:
5/24/2014 10:25 am

Cost Center Description		Costs		Title XVIII	Hospital	PPS
		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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		61.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0		91.00
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: 153043

Period:
From 07/16/2013
To 12/31/2013

Worksheet D-1

Date/Time Prepared:
5/24/2014 10:25 am

Cost Center Description		Title XVIII	Hospital	PPS	
				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,744	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,744	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)			3,744	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			925	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)			4,303,157	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			4,303,157	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)			4,303,157	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)			1,149.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,063,149	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)			1,063,149	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

worksheet D-1

Date/Time Prepared:
5/24/2014 10:25 am

Cost Center Description	Title XVIII			Hospital Program Days	PPS Program Cost (col. 3 x col. 4)		
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 + col. 2)				
42.00	1.00	2.00	3.00	4.00	5.00	42.00	
NURSERY (title V & XIX only)							
Intensive Care Type Inpatient Hospital Units							
43.00						43.00	
44.00						44.00	
45.00						45.00	
46.00						46.00	
47.00						47.00	
Cost Center Description							
48.00					1.00		
Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)						573,034	
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,636,183	48.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					245,208	49.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					44,830	50.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					290,038	51.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,346,145	52.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	53.00
55.00	Target amount per discharge					0.00	54.00
56.00	Target amount (line 54 x line 55)					0	55.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	56.00
58.00	Bonus payment (see instructions)					0	57.00
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	58.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	59.00
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	60.00
62.00	Relief payment (see instructions)					0	61.00
63.00	Allowable inpatient cost plus incentive payment (see instructions)					0	62.00
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	63.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	65.00
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	66.00
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	67.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	68.00
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)						69.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 + line 2)						70.00
72.00	Program routine service cost (line 9 x line 71)						71.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						72.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						73.00
75.00	Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						74.00
76.00	Per diem capital-related costs (line 75 + line 2)						75.00
77.00	Program capital-related costs (line 9 x line 76)						76.00
78.00	Inpatient routine service cost (line 74 minus line 77)						77.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						78.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						79.00
81.00	Inpatient routine service cost per diem limitation						80.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						81.00
83.00	Reasonable inpatient routine service costs (see instructions)						82.00
84.00	Program inpatient ancillary services (see instructions)						83.00
85.00	Utilization review - physician compensation (see instructions)						84.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						85.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	86.00
88.00	Adjusted general inpatient routine cost per diem (line 27 + line 2)					0.00	87.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	88.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

worksheet D-1

Date/Time Prepared:
5/24/2014 10:25 am

Cost Center Description	Title XVIII			Hospital	PPS	
	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	992,500	4,303,157	0.230645	0	0	90.00
91.00 Nursing School cost	0	4,303,157	0.000000	0	0	91.00
92.00 Allied health cost	0	4,303,157	0.000000	0	0	92.00
93.00 All other Medical Education	0	4,303,157	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

Worksheet D-3

Date/Time Prepared:
5/24/2014 10:25 am

Cost Center Description		Title XVIII		Hospital		PPS
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)		
		1.00	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		1,237,883			30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.000000	0	0		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.237598	21,119	5,018		54.00
60.00	06000 LABORATORY	0.047861	126,042	6,032		60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0		60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0		61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0		62.00
65.00	06500 RESPIRATORY THERAPY	1.950872	12,822	25,014		65.00
66.00	06600 PHYSICAL THERAPY	0.576827	385,035	222,099		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.329535	376,731	124,146		67.00
68.00	06800 SPEECH PATHOLOGY	0.263496	271,125	71,440		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9.312197	6,097	56,776		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.234566	266,490	62,509		73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0		74.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0.000000	0	0		91.00
200.00	Total (sum of lines 50-94 and 96-98)		1,465,461	573,034		200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0			201.00
202.00	Net Charges (line 200 minus line 201)		1,465,461			202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 153043	Period: From 07/16/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/24/2014 10:25 am
Title XVIII	Hospital	PPS

	1.00	
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PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0 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)	0 11.00

COMPUTATION OF LESSER OF COST OR CHARGES		
Reasonable charges		
12.00	Ancillary service charges	0 12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)	0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0 14.00
Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000 17.00
18.00	Total customary charges (see instructions)	0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0 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)	0 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0 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)	0 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)	0 30.00
31.00	Primary payer payments	0 31.00
32.00	Subtotal (line 30 minus line 31)	0 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)	0 34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0 36.00
37.00	Subtotal (see instructions)	0 37.00
38.00	MSP-LCC reconciliation amount from PS&R	0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0 39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0 39.99
40.00	Subtotal (see instructions)	0 40.00
40.01	Sequestration adjustment (see instructions)	0 40.01
41.00	Interim payments	0 41.00
42.00	Tentative settlement (for contractors use only)	0 42.00
43.00	Balance due provider/program (see instructions)	0 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: 153043

Period:
From 07/16/2013
To 12/31/2013

Worksheet E-1
Part I
Date/Time Prepared:
5/24/2014 10:25 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,191,114		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)		1,191,114		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		39,750		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		1,230,864		0		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
			0	1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

Worksheet E-3
Part III
Date/Time Prepared:
5/24/2014 10:25 am

		Title XVIII		Hospital		PPS	
		Prior to 10/01		On/After 10/01			
		1.00		1.01			
PART III - MEDICARE PART A SERVICES - IRF PPS							
1.00	Net Federal PPS Payment (see instructions)	1,193,684		0		1.00	
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0280				2.00	
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	39,750		0		3.00	
4.00	Outlier Payments	63,398				4.00	
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00				5.00	
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00				5.01	
6.00	New Teaching program adjustment. (see instructions)	0.00				6.00	
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program". (see inst.)	0.00				7.00	
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program". (see inst.)	0.00				8.00	
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00				9.00	
10.00	Average Daily Census (see instructions)	22.153846				10.00	
11.00	Teaching Adjustment Factor (see instructions)	0.000000		0.000000		11.00	
12.00	Teaching Adjustment (see instructions)	0		0		12.00	
13.00	Total PPS Payment (see instructions)	1,296,832				13.00	
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0				14.00	
15.00	Organ acquisition (DO NOT USE THIS LINE)					15.00	
16.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)	0				16.00	
17.00	Subtotal (see instructions)	1,296,832				17.00	
18.00	Primary payer payments	0				18.00	
19.00	Subtotal (line 17 less line 18).	1,296,832				19.00	
20.00	Deductibles	8,288				20.00	
21.00	Subtotal (line 19 minus line 20)	1,288,544				21.00	
22.00	Coinsurance	32,560				22.00	
23.00	Subtotal (line 21 minus line 22)	1,255,984				23.00	
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0				24.00	
25.00	Adjusted reimbursable bad debts (see instructions)	0				25.00	
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0				26.00	
27.00	Subtotal (sum of lines 23 and 25)	1,255,984				27.00	
28.00	Direct graduate medical education payments (from worksheet E-4, line 49)	0				28.00	
29.00	Other pass through costs (see instructions)	0				29.00	
30.00	Outlier payments reconciliation	0				30.00	
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0				31.00	
31.99	Recovery of Accelerated Depreciation	0				31.99	
32.00	Total amount payable to the provider (see instructions)	1,255,984				32.00	
32.01	Sequestration adjustment (see instructions)	25,120				32.01	
33.00	Interim payments	1,191,114				33.00	
34.00	Tentative settlement (for contractor use only)	0				34.00	
35.00	Balance due provider/program line 32 minus lines 32.01, 33 and 34	39,750				35.00	
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0				36.00	
TO BE COMPLETED BY CONTRACTOR							
50.00	Original outlier amount from worksheet E-3, Part III, line 4	63,398				50.00	
51.00	Outlier reconciliation adjustment amount (see instructions)	0				51.00	
52.00	The rate used to calculate the Time value of Money	0.00				52.00	
53.00	Time value of Money (see instructions)	0				53.00	

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

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

Worksheet G

Date/Time Prepared:
5/24/2014 10:25 am

		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	2,475,314	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	5,867,667	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-74,361	0	0	0	6.00
7.00	Inventory	172,865	0	0	0	7.00
8.00	Prepaid expenses	67,002	0	0	0	8.00
9.00	Other current assets	-3,112,071	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	5,396,416	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	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	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	6,733	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	2,314,281	0	0	0	23.00
24.00	Accumulated depreciation	-224,876	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)	2,096,138	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	9,524	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	8,500,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,509,524	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	16,002,078	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,815,261	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	418,660	0	0	0	39.00
40.00	Notes and loans payable (short term)	47,407	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	458,293	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,739,621	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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,739,621	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	13,262,457	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)	13,262,457	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	16,002,078	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

Worksheet G-1

Date/Time Prepared:
5/24/2014 10:25 am

		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		16,414,805			0	1.00
2.00	Net income (loss) (from wkst. G-3, line 29)		-3,152,351				2.00
3.00	Total (sum of line 1 and line 2)		13,262,454			0	3.00
4.00	ROUNDING	3			0	0	4.00
5.00		0			0	0	5.00
6.00		0			0	0	6.00
7.00		0			0	0	7.00
8.00		0			0	0	8.00
9.00		0			0	0	9.00
10.00	Total additions (sum of line 4-9)		3			0	10.00
11.00	Subtotal (line 3 plus line 10)		13,262,457			0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		13,262,457			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	ROUNDING		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: 153043

Period:
From 07/16/2013
To 12/31/2013

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/24/2014 10:25 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	5,656,074		5,656,074	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,656,074		5,656,074	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,656,074		5,656,074	17.00
18.00	Ancillary services	5,835,609	0	5,835,609	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00		0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	11,491,683	0	11,491,683	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		8,405,206		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		8,405,206		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 153043

Period:
From 07/16/2013
To 12/31/2013

worksheet G-3

Date/Time Prepared:
5/24/2014 10:25 am

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	11,491,683	1.00
2.00	Less contractual allowances and discounts on patients' accounts	6,255,147	2.00
3.00	Net patient revenues (line 1 minus line 2)	5,236,536	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	8,405,206	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,168,670	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	16,320	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		0	24.00
24.01	ROUNDING	-1	24.01
25.00	Total other income (sum of lines 6-24)	16,319	25.00
26.00	Total (line 5 plus line 25)	-3,152,351	26.00
27.00	LOSS FROM DISPOSAL	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-3,152,351	29.00