

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151300	Period: From 05/01/2012 To 04/30/2013	Worksheet S Parts I-III Date/Time Prepared: 9/30/2013 12:42 pm
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**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 9/30/2013 Time: 12:42 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPITAL OF BREMEN ( 151300 ) for the cost reporting period beginning 05/01/2012 and ending 04/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) \_\_\_\_\_  
Officer or Administrator of Provider(s)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00		
		Part A 2.00	Part B 3.00				
<b>PART III - SETTLEMENT SUMMARY</b>							
1.00	Hospital	0	-36,702	131,289	0	302,146	1.00
2.00	Subprovider - IPF	0	0	0	0	0	2.00
3.00	Subprovider - IRF	0	0	0	0	0	3.00
4.00	SUBPROVIDER I	0	0	0	0	0	4.00
5.00	Swing bed - SNF	0	-47,114	0	0	0	5.00
6.00	Swing bed - NF	0	0	0	0	0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00	RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
200.00	Total	0	-83,816	131,289	0	302,146	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

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**PART I - COST REPORT STATUS**

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

Date: 9/30/2013 Time: 12:42 pm

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

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Encryption Information  
 ECR: Date: 9/30/2013 Time: 12:42 pm  
 UN: RhpI DdJksLCZQK: I d. ycD8KeBq0  
 saEJa0LSWhnz9TvdXqpJi w. xGfpUej  
 9uZi 0LVI Bk055ml u  
 PI: Date: 9/30/2013 Time: 12:42 pm  
 dAND: GOi kG1ECm46cAznxwQ1PhLU60  
 tadpz0nt1hj 4T4SaQLBI ktl Le7L. m  
 ineC0. Z7cf06GygG

(Signed) \_\_\_\_\_  
 Officer or Administrator of Provider(s)  
 \_\_\_\_\_  
 Title  
 \_\_\_\_\_  
 Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00		
		Part A 2.00	Part B 3.00				
<b>PART III - SETTLEMENT SUMMARY</b>							
1.00	Hospital	0	-36,702	131,289	0	302,146	1.00
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3.00	Subprovider - IRF	0	0	0	0	0	3.00
4.00	SUBPROVIDER I	0	0	0	0	0	4.00
5.00	Swing bed - SNF	0	-47,114	0	0	0	5.00
6.00	Swing bed - NF	0	0	0	0	0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00	RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
200.00	Total	0	-83,816	131,289	0	302,146	200.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151300	Period: From 05/01/2012 To 04/30/2013	Worksheet S-2 Part I Date/Time Prepared: 9/30/2013 11:06 am
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1.00	2.00	3.00	4.00	1.00
Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1020 HIGH RD	PO Box: 1506	Zip Code: 46506-	1.00
2.00	City: BREMEN	State: IN	County: MARSHALL	2.00

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
						V	XVIII	XIX		
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	COMMUNITY HOSPITAL OF BREMEN	151300	99915	1	07/01/1966	0	0	0	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	COMMUNITY HOSPITAL SWING BED	15Z300	99915		05/01/1984	N	0	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
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)	05/01/2012	04/30/2013	20.00
21.00	Type of Control (see instructions)	2		21.00

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

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	25.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151300	Period: From 05/01/2012 To 04/30/2013	Worksheet S-2 Part I Date/Time Prepared: 9/30/2013 11:06 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 the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.					39.00
		V 1.00	XVIII 2.00	XIX 3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
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
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00		0.00	61.00
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
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
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>						
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 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151300

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet S-2  
Part I  
Date/Time Prepared:  
9/30/2013 11:06 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	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. 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	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		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	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

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		1.00	2.00	3.00		
<b>Inpatient Psychiatric Facility PPS</b>						
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 subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		71.00
<b>Inpatient Rehabilitation Facility PPS</b>						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N				75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		76.00
				1.00		
<b>Long Term Care Hospital PPS</b>						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00	
<b>TEFRA Providers</b>						
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	
<b>Title V and XIX Services</b>						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00	
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	97.00
<b>Rural Providers</b>						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	Y	N	109.00
				1.00	2.00	3.00
<b>Miscellaneous Cost Reporting Information</b>						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2				118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151300	Period: From 05/01/2012 To 04/30/2013	Worksheet S-2 Part I Date/Time Prepared: 9/30/2013 11:06 am	
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	154,933	0	0	
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		
119.00	DO NOT USE THIS LINE				
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N	
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N		
<b>Transplant Center Information</b>					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				
<b>All Providers</b>					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		N		
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	Contractor's Name:		Contractor's Number:	
142.00	Street:	PO Box:			
143.00	City:	State:		Zip Code:	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y	
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.			N	
			1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		
		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
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
161.10	CORF		N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151300			Period: From 05/01/2012 To 04/30/2013		Worksheet S-2 Part I Date/Time Prepared: 9/30/2013 11:06 am	
							1.00	
<b>Multi campus</b>								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
<b>Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act</b>								
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)							168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151300	Period: From 05/01/2012 To 04/30/2013	Worksheet S-2 Part II Date/Time Prepared: 9/30/2013 11:06 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	09/03/2013	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	Y		Y	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151300		Period: From 05/01/2012 To 04/30/2013		Worksheet S-2 Part II Date/Time Prepared: 9/30/2013 11:06 am	
	Description	Part A		Part B			
		Y/N	Date	Y/N			
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N					21.00
						1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>							
<b>Capital Related Cost</b>							
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions					N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.					N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					N	27.00
<b>Interest Expense</b>							
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
<b>Purchased Services</b>							
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
<b>Provider-Based Physicians</b>							
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.					Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.					N	35.00
						1.00	
						2.00	
<b>Home Office Costs</b>							
36.00	Were home office costs claimed on the cost report?					N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					N	40.00
						1.00	
						2.00	
<b>Cost Report Preparer Contact Information</b>							
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.	STACEY		THOMAS			41.00
42.00	Enter the employer/company name of the cost report preparer.	STACEY THOMAS					42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	260-432-8870		STHOMAS797@AOL.COM			43.00

		Part B	
		Date	
		4.00	
<b>PS&amp;R Data</b>			
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)	09/03/2013	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
<b>Cost Report Preparer Contact Information</b>			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CONSULTANT	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HFS Supplemental Information		Provider CCN: 151300	Period: From 05/01/2012 To 04/30/2013	Worksheet S-2 Part IX Date/Time Prepared: 9/30/2013 11:06 am	
			Title V	Title XIX	
			1.00	2.00	
<b>TITLES V AND/OR XIX FOLLOWING MEDICARE</b>					
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	3.00
			Inpatient	Outpatient	
			1.00	2.00	
<b>CRITICAL ACCESS HOSPITALS</b>					
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.		N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.		N	N	5.00
			Title V	Title XIX	
			1.00	2.00	
<b>RCE DISALLOWANCE</b>					
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	6.00
<b>PASS THROUGH COST</b>					
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151300

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet S-3  
Part I  
Date/Time Prepared:  
9/30/2013 11:06 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					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)	30.00	25	9,125	31,490.00	0	1.00
2.00 HMO						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	31,490.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00 CORONARY CARE UNIT	32.00	0	0	0.00	0	9.00
10.00 BURN INTENSIVE CARE UNIT	33.00	0	0	0.00	0	10.00
11.00 SURGICAL INTENSIVE CARE UNIT	34.00	0	0	0.00	0	11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,125	31,490.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	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	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151300

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet S-3  
Part I  
Date/Time Prepared:  
9/30/2013 11:06 am

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)	596	93	1,197			1.00
2.00 HMO	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	326	0	326			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	134			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	922	93	1,657			7.00
8.00 INTENSIVE CARE UNIT	0	0	0			8.00
9.00 CORONARY CARE UNIT	0	0	0			9.00
10.00 BURN INTENSIVE CARE UNIT	0	0	0			10.00
11.00 SURGICAL INTENSIVE CARE UNIT	0	0	0			11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		73	147			13.00
14.00 Total (see instructions)	922	166	1,804	0.00	108.80	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	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	0	0	0	0.00	0.00	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	108.80	27.00
28.00 Observation Bed Days		0	337			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151300

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet S-3  
Part I  
Date/Time Prepared:  
9/30/2013 11:06 am

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)			0	199	44	436	1.00
2.00 HMO				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	199	44	436	436	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	0	17.00
18.00 SUBPROVIDER	0.00	0	0	0	0	0	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	0.00						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
25.00 CMHC - CMHC							25.00
25.10 CMHC - CORF	0.00						25.10
26.00 RURAL HEALTH CLINIC	0.00						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
33.00 LTCH non-covered days							33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151300	Period: From 05/01/2012 To 04/30/2013	Worksheet S-10 Date/Time Prepared: 9/30/2013 11:06 am
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				1.00	
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.503599		1.00
<b>Medicaid (see instructions for each line)</b>					
2.00	Net revenue from Medicaid		451,232		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0		5.00
6.00	Medicaid charges		2,340,092		6.00
7.00	Medicaid cost (line 1 times line 6)		1,178,468		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		727,236		8.00
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>					
9.00	Net revenue from stand-alone SCHIP		0		9.00
10.00	Stand-alone SCHIP charges		0		10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0		11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00
<b>Other state or local government indigent care program (see instructions for each line)</b>					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00
<b>Uncompensated care (see instructions for each line)</b>					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		727,236		19.00
				1.00	
				Uninsured patients	
				Insured patients	
				Total (col. 1 + col. 2)	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	751,170	0	751,170	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	378,288	0	378,288	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	378,288	0	378,288	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		575,351		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		82,289		27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		493,062		28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		248,306		29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		626,594		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,353,830		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151300

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet A  
Date/Time Prepared:  
9/30/2013 11:06 am

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT		0	0	1,889,736	1,889,736	1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
3.00 00300 OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00 00400 EMPLOYEE BENEFITS	77,444	21,083	98,527	1,384,295	1,482,822	4.00
5.00 00500 ADMIN STRATIVE & GENERAL	806,651	5,342,642	6,149,293	-3,615,792	2,533,501	5.00
7.00 00700 OPERATION OF PLANT	171,959	142,950	314,909	311,874	626,783	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	140,646	140,646	0	140,646	8.00
9.00 00900 HOUSEKEEPING	150,718	25,127	175,845	0	175,845	9.00
10.00 01000 DIETARY	208,965	243,638	452,603	-387,055	65,548	10.00
11.00 01100 CAFETERIA	0	0	0	387,055	387,055	11.00
13.00 01300 NURSING ADMINISTRATION	194,054	11,650	205,704	0	205,704	13.00
16.00 01600 MEDICAL RECORDS & LIBRARY	217,444	73,242	290,686	0	290,686	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	734,612	147,696	882,308	-27,418	854,890	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00 03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00 04100 SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300 NURSERY	0	0	0	6,368	6,368	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	616,351	1,368,201	1,984,552	-401,728	1,582,824	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	8,283	8,283	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	431,293	312,932	744,225	-38	744,187	54.00
57.00 05700 CT SCAN	51,268	305,670	356,938	-11,936	345,002	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	46,550	247,353	293,903	-6,631	287,272	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	493,319	660,967	1,154,286	-648	1,153,638	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	0	15,057	15,057	-9,656	5,401	65.00
66.00 06600 PHYSICAL THERAPY	260,573	16,814	277,387	-6,891	270,496	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	3,200	3,200	68.00
69.00 06900 ELECTROCARDIOLOGY	0	67,522	67,522	0	67,522	69.00
69.02 06902 SLEEP LAB	0	44,700	44,700	0	44,700	69.02
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	99,821	33,902	133,723	458,688	592,411	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	223,593	266,866	490,459	0	490,459	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	1,302,815	193,523	1,496,338	22,062	1,518,400	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10 09910 CORF	0	0	0	0	0	99.10
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00
112.00 08600 OTHER ORGAN ACQUISITION	0	0	0	0	0	112.00
113.00 11300 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	6,087,430	9,682,181	15,769,611	3,768	15,773,379	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	58,028	54,315	112,343	-3,768	108,575	192.00
200.00 TOTAL (SUM OF LINES 118-199)	6,145,458	9,736,496	15,881,954	0	15,881,954	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151300

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet A  
Date/Time Prepared:  
9/30/2013 11:06 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-11,265	1,878,471	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	00300 OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS	0	1,482,822	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-728,909	1,804,592	5.00
7.00	00700 OPERATION OF PLANT	-4,925	621,858	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	140,646	8.00
9.00	00900 HOUSEKEEPING	-2,137	173,708	9.00
10.00	01000 DIETARY	-10,260	55,288	10.00
11.00	01100 CAFETERIA	-114,852	272,203	11.00
13.00	01300 NURSING ADMINISTRATION	0	205,704	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-4,027	286,659	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS	-11,025	843,865	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	31.00
32.00	03200 CORONARY CARE UNIT	0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	34.00
41.00	04100 SUBPROVIDER - IRF	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	42.00
43.00	04300 NURSERY	0	6,368	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	-463,139	1,119,685	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	8,283	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	-1,987	742,200	54.00
57.00	05700 CT SCAN	0	345,002	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	287,272	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	1,153,638	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	5,401	65.00
66.00	06600 PHYSICAL THERAPY	0	270,496	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	3,200	68.00
69.00	06900 ELECTROCARDIOLOGY	0	67,522	69.00
69.02	06902 SLEEP LAB	0	44,700	69.02
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-19,866	572,545	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	490,459	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	-352,865	1,165,535	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0	0	95.00
99.10	09910 CORF	0	0	99.10
101.00	10100 HOME HEALTH AGENCY	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
109.00	10900 PANCREAS ACQUISITION	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	111.00
112.00	08600 OTHER ORGAN ACQUISITION	0	0	112.00
113.00	11300 INTEREST EXPENSE	0	0	113.00
118.00	11800 SUBTOTALS (SUM OF LINES 1-117)	-1,725,257	14,048,122	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	108,575	192.00
200.00	20000 TOTAL (SUM OF LINES 118-199)	-1,725,257	14,156,697	200.00

COST CENTERS USED IN COST REPORT		Provider CCN: 151300	Period: From 05/01/2012 To 04/30/2013	Worksheet Non-CMS W Date/Time Prepared: 9/30/2013 11:06 am
Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	NEW CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAPITAL RELATED COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
32.00	CORONARY CARE UNIT	03200		32.00
33.00	BURN INTENSIVE CARE UNIT	03300		33.00
34.00	SURGICAL INTENSIVE CARE UNIT	03400		34.00
41.00	SUBPROVIDER - IRF	04100		41.00
42.00	SUBPROVIDER	04200		42.00
43.00	NURSERY	04300		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	05000		50.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
57.00	CT SCAN	05700		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
59.00	CARDIAC CATHETERIZATION	05900		59.00
60.00	LABORATORY	06000		60.00
60.01	BLOOD LABORATORY	06001		60.01
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
69.02	SLEEP LAB	06902		69.02
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	RURAL HEALTH CLINIC	08800		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	08900		89.00
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	AMBULANCE SERVICES	09500		95.00
99.10	CORF	09910		99.10
101.00	HOME HEALTH AGENCY	10100		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
109.00	PANCREAS ACQUISITION	10900		109.00
110.00	INTESTINAL ACQUISITION	11000		110.00
111.00	ISLET ACQUISITION	11100		111.00
112.00	OTHER ORGAN ACQUISITION	08600		112.00
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
200.00	TOTAL (SUM OF LINES 118-199)			200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - UNASSIGNED COSTS</b>					
1.00	EMPLOYEE BENEFITS	4.00	0	1,384,295	1.00
2.00	OPERATION OF PLANT	7.00	0	311,874	2.00
3.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,219,640	3.00
	TOTALS		0	2,915,809	
<b>B - NURSING</b>					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	6,573	1,710	1.00
2.00	NURSERY	43.00	5,053	1,315	2.00
	TOTALS		11,626	3,025	
<b>C - CAFETERIA COSTS</b>					
1.00	CAFETERIA	11.00	178,702	208,353	1.00
	TOTALS		178,702	208,353	
<b>D - INTEREST</b>					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	670,096	1.00
	TOTALS		0	670,096	
<b>E - SPEECH PURCHASED SVC</b>					
1.00	SPEECH PATHOLOGY	68.00	0	3,200	1.00
	TOTALS		0	3,200	
<b>F - CHARGABLE SUPPLIES</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	458,688	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
	TOTALS		0	458,688	
<b>G - YELLOW PAGES</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,768	1.00
	TOTALS		0	3,768	
<b>H - ER CONTRACTED PHYS</b>					
1.00	EMERGENCY	91.00	0	33,655	1.00
	TOTALS		0	33,655	
500.00	Grand Total: Increases		190,328	4,296,594	500.00

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
<b>A - UNASSIGNED COSTS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,915,809	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
TOTALS			0	2,915,809			
<b>B - NURSING</b>							
1.00	ADULTS & PEDIATRICS	30.00	11,626	3,025	0		1.00
2.00		0.00	0	0	0		2.00
TOTALS			11,626	3,025			
<b>C - CAFETERIA COSTS</b>							
1.00	DIETARY	10.00	178,702	208,353	0		1.00
TOTALS			178,702	208,353			
<b>D - INTEREST</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	670,096	10		1.00
TOTALS			0	670,096			
<b>E - SPEECH PURCHASED SVC</b>							
1.00	PHYSICAL THERAPY	66.00	0	3,200	0		1.00
TOTALS			0	3,200			
<b>F - CHARGABLE SUPPLIES</b>							
1.00	ADULTS & PEDIATRICS	30.00	0	12,767	0		1.00
2.00	OPERATING ROOM	50.00	0	401,728	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	38	0		3.00
4.00	LABORATORY	60.00	0	648	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	3,691	0		5.00
6.00	EMERGENCY	91.00	0	11,593	0		6.00
7.00	CT SCAN	57.00	0	11,936	0		7.00
8.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	6,631	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	9,656	0		9.00
TOTALS			0	458,688			
<b>G - YELLOW PAGES</b>							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3,768	0		1.00
TOTALS			0	3,768			
<b>H - ER CONTRACTED PHYS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	33,655	0		1.00
TOTALS			0	33,655			
500.00	Grand Total: Decreases		190,328	4,296,594			500.00

Increases			Decreases			
Cost Center	Line #	Salary	Cost Center	Line #	Salary	
2.00	3.00	4.00	6.00	7.00	8.00	
<b>A - UNASSIGNED COSTS</b>						
1.00	EMPLOYEE BENEFITS	4.00	ADMINISTRATIVE & GENERAL	5.00	0	1.00
2.00	OPERATION OF PLANT	7.00		0.00	0	2.00
3.00	NEW CAP REL COSTS-BLDG & FIXT	1.00		0.00	0	3.00
	TOTALS		TOTALS		0	
<b>B - NURSING</b>						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	ADULTS & PEDIATRICS	30.00	11,626	1.00
2.00	NURSERY	43.00		0.00	0	2.00
	TOTALS	11,626	TOTALS		11,626	
<b>C - CAFETERIA COSTS</b>						
1.00	CAFETERIA	11.00	DIETARY	10.00	178,702	1.00
	TOTALS	178,702	TOTALS		178,702	
<b>D - INTEREST</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	ADMINISTRATIVE & GENERAL	5.00	0	1.00
	TOTALS		TOTALS		0	
<b>E - SPEECH PURCHASED SVC</b>						
1.00	SPEECH PATHOLOGY	68.00	PHYSICAL THERAPY	66.00	0	1.00
	TOTALS		TOTALS		0	
<b>F - CHARGABLE SUPPLIES</b>						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	ADULTS & PEDIATRICS	30.00	0	1.00
2.00		0.00	OPERATING ROOM	50.00	0	2.00
3.00		0.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3.00
4.00		0.00	LABORATORY	60.00	0	4.00
5.00		0.00	PHYSICAL THERAPY	66.00	0	5.00
6.00		0.00	EMERGENCY	91.00	0	6.00
7.00		0.00	CT SCAN	57.00	0	7.00
8.00		0.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	8.00
9.00		0.00	RESPIRATORY THERAPY	65.00	0	9.00
	TOTALS		TOTALS		0	
<b>G - YELLOW PAGES</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1.00
	TOTALS		TOTALS		0	
<b>H - ER CONTRACTED PHYS</b>						
1.00	EMERGENCY	91.00	ADMINISTRATIVE & GENERAL	5.00	0	1.00
	TOTALS		TOTALS		0	
500.00	Grand Total: Increases		Grand Total: Decreases		190,328	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151300

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet A-7  
Part I  
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	Beginning Balances	Acquisitions			Disposals and Retirements		
		Purchases	Donation	Total			
		1.00	2.00	3.00			4.00
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	440,039	0	0	0	1.00	
2.00	Land Improvements	0	0	0	0	2.00	
3.00	Buildings and Fixtures	17,285,369	454,737	0	454,737	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	6,252,977	489,005	0	489,005	6.00	
7.00	HIT designated Assets	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	23,978,385	943,742	0	943,742	8.00	
9.00	Reconciling Items	-927,240	0	0	0	-729,414	9.00
10.00	Total (line 8 minus line 9)	24,905,625	943,742	0	943,742	729,414	10.00
	Ending Balance		Fully Depreciated Assets				
	6.00		7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	440,039	0			1.00	
2.00	Land Improvements	0	0			2.00	
3.00	Buildings and Fixtures	17,740,106	0			3.00	
4.00	Building Improvements	0	0			4.00	
5.00	Fixed Equipment	0	0			5.00	
6.00	Movable Equipment	6,741,982	0			6.00	
7.00	HIT designated Assets	0	0			7.00	
8.00	Subtotal (sum of lines 1-7)	24,922,127	0			8.00	
9.00	Reconciling Items	-197,826	0			9.00	
10.00	Total (line 8 minus line 9)	25,119,953	0			10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151300

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet A-7  
Part II  
Date/Time Prepared:  
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Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	NEW 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	NEW CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	NEW 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: 151300

Period:  
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Worksheet A-7  
Part III  
Date/Time Prepared:  
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	17,740,106	0	17,740,106	0.724616	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	6,741,982	0	6,741,982	0.275384	0	2.00
3.00	Total (sum of lines 1-2)	24,482,088	0	24,482,088	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,208,375	670,096	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,208,375	670,096	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,878,471	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,878,471	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151300

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet A-8

Date/Time Prepared:  
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7	Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)	B	-26,983	ADMINISTRATIVE & GENERAL	5.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-5,620	ADMINISTRATIVE & GENERAL	5.00		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	-827,029				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	B	-1,987	RADIOLOGY-DIAGNOSTIC	54.00		0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0				0	12.00
13.00 Laundry and linen service		0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-114,852	CAFETERIA	11.00		0	14.00
15.00 Rental of quarters to employee and others		0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients	B	-19,866	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		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	-4,027	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	-2,838	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		ORESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			ONEW CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			ONEW CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant			0	0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00			30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00		0	32.00
33.00 MEALS ON WHEELS	B	-10,260	DIETARY	10.00		0	33.00
34.00 MISC INCOME	B	-44,857	ADMINISTRATIVE & GENERAL	5.00		0	34.00

Provider CCN: 151300

Period:  
 From 05/01/2012  
 To 04/30/2013

Worksheet A-8

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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
35.00 INVOICE PENALTIES	A	-3,724	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00 RECRUITING/MD SUPPORT	A	-114,593	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00 LOBBYING EXP IN DUES	A	-1,353	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00 PLYMOUTH ST CLINIC DEPR	A	-11,265	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	38.00
39.00 HAF PROVIDER ASSESSMENT	A	-528,941	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00 PLYMOUTH ST HOUSEKEEPING	A	-2,137	HOUSEKEEPING	9.00	0	40.00
41.00 PLYMOUTH ST MAINTENANCE	A	-4,925	OPERATION OF PLANT	7.00	0	41.00
42.00		0		0.00	0	42.00
43.00		0		0.00	0	43.00
44.00		0		0.00	0	44.00
45.00		0		0.00	0	45.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,725,257				50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151300

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet A-8-2

Date/Time Prepared:  
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	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	463,139	463,139	0	0	0	1.00
2.00	91.00	EMERGENCY	883,046	352,865	530,181	0	0	2.00
3.00	60.00	LABORATORY	21,600	0	21,600	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	11,025	11,025	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,378,810	827,029	551,781			200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	50.00	OPERATING ROOM	0	0	0	463,139	1.00
2.00	91.00	EMERGENCY	0	0	0	352,865	2.00
3.00	60.00	LABORATORY	0	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	11,025	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	827,029	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151300	Period: From 05/01/2012 To 04/30/2013	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/30/2013 11:06 am			
			Speech Pathology	Cost			
			1.00				
<b>PART I - GENERAL INFORMATION</b>							
1.00	Total number of weeks worked (excluding aides) (see instructions)			31	1.00		
2.00	Line 1 multiplied by 15 hours per week			465	2.00		
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)			10	3.00		
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)			0	4.00		
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)			0	5.00		
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)			0	6.00		
7.00	Standard travel expense rate			9.77	7.00		
8.00	Optional travel expense rate per mile			0.00	8.00		
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	37.37	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	22.00	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	11.00	11.00	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>							
14.00	Supervisors (column 1, line 9 times column 1, line 10)			0	14.00		
15.00	Therapists (column 2, line 9 times column 2, line 10)			822	15.00		
16.00	Assistants (column 3, line 9 times column 3, line 10)			0	16.00		
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)			822	17.00		
18.00	Aides (column 4, line 9 times column 4, line 10)			0	18.00		
19.00	Trainees (column 5, line 9 times column 5, line 10)			0	19.00		
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)			822	20.00		
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)			22.00	21.00		
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)			10,230	22.00		
23.00	Total salary equivalency (see instructions)			10,230	23.00		
<b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE</b>							
<b>Standard Travel Allowance</b>							
24.00	Therapists (line 3 times column 2, line 11)			110	24.00		
25.00	Assistants (line 4 times column 3, line 11)			0	25.00		
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)			110	26.00		
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)			98	27.00		
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)			208	28.00		
<b>Optional Travel Allowance and Optional Travel Expense</b>							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)			0	29.00		
30.00	Assistants (column 3, line 10 times column 3, line 12)			0	30.00		
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)			0	31.00		
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)			0	32.00		
33.00	Standard travel allowance and standard travel expense (line 28)			0	33.00		
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)			0	34.00		
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)			0	35.00		
<b>Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE</b>							
<b>Standard Travel Expense</b>							
36.00	Therapists (line 5 times column 2, line 11)			0	36.00		
37.00	Assistants (line 6 times column 3, line 11)			0	37.00		
38.00	Subtotal (sum of lines 36 and 37)			0	38.00		
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)			0	39.00		
<b>Optional Travel Allowance and Optional Travel Expense</b>							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)			0	40.00		
41.00	Assistants (column 3, line 12.01 times column 3, line 10)			0	41.00		
42.00	Subtotal (sum of lines 40 and 41)			0	42.00		
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)			0	43.00		
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)			0	44.00		
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)			0	45.00		

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151300				Period: From 05/01/2012 To 04/30/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/30/2013 11:06 am	
						Speech Pathology		Cost	
								1.00	
46.00 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)								0 46.00	
		Therapists	Assistants	Aides	Trainees	Total			
		1.00	2.00	3.00	4.00	5.00			
<b>PART V - OVERTIME COMPUTATION</b>									
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00		49.00	
<b>CALCULATION OF LIMIT</b>									
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00		51.00	
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>									
52.00	Adjusted hourly salary equivalency amount (see instructions)	22.00	0.00	0.00	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0		56.00	
								1.00	
<b>Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT</b>									
57.00	Salary equivalency amount (from line 23)							10,230 57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))							0 58.00	
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)							0 59.00	
60.00	Overtime allowance (from column 5, line 56)							0 60.00	
61.00	Equipment cost (see instructions)							0 61.00	
62.00	Supplies (see instructions)							0 62.00	
63.00	Total allowance (sum of lines 57-62)							10,230 63.00	
64.00	Total cost of outside supplier services (from your records)							3,200 64.00	
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)							0 65.00	
<b>LINE 33 CALCULATION</b>									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others							110 100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							98 100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27							208 100.02	
<b>LINE 34 CALCULATION</b>									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							98 101.00	
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							0 101.01	
101.02	Line 34 = sum of lines 27 and 31							98 101.02	
<b>LINE 35 CALCULATION</b>									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							0 102.00	
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others							0 102.01	
102.02	Line 35 = sum of lines 31 and 32							0 102.02	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151300

Period:  
From 05/01/2012  
To 04/30/2013

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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal		
		NEW BLDG & FIXT	NEW MVBLE EQUIP				
		1.00	2.00				4.00
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	1,878,471	1,878,471				1.00	
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	0		0			2.00	
4.00 00400 EMPLOYEE BENEFITS	1,482,822	6,495	0	1,489,317		4.00	
5.00 00500 ADMINISTRATIVE & GENERAL	1,804,592	190,761	0	197,982	2,193,335	5.00	
7.00 00700 OPERATION OF PLANT	621,858	336,963	0	42,205	1,001,026	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	140,646	0	0	0	140,646	8.00	
9.00 00900 HOUSEKEEPING	173,708	11,059	0	36,992	221,759	9.00	
10.00 01000 DIETARY	55,288	43,389	0	7,428	106,105	10.00	
11.00 01100 CAFETERIA	272,203	36,748	0	43,860	352,811	11.00	
13.00 01300 NURSING ADMINISTRATION	205,704	22,119	0	47,628	275,451	13.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	286,659	55,414	0	53,369	395,442	16.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	843,865	357,621	0	177,448	1,378,934	30.00	
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
32.00 03200 CORONARY CARE UNIT	0	0	0	0	0	32.00	
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00	
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00	
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00	
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00	
43.00 04300 NURSERY	6,368	8,543	0	1,240	16,151	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	1,119,685	241,407	0	151,275	1,512,367	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	8,283	0	0	1,613	9,896	52.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	742,200	92,045	0	105,855	940,100	54.00	
57.00 05700 CT SCAN	345,002	17,408	0	12,583	374,993	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	287,272	4,184	0	11,425	302,881	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00 06000 LABORATORY	1,153,638	70,511	0	121,079	1,345,228	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01	
65.00 06500 RESPIRATORY THERAPY	5,401	0	0	0	5,401	65.00	
66.00 06600 PHYSICAL THERAPY	270,496	82,390	0	63,954	416,840	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	3,200	0	0	0	3,200	68.00	
69.00 06900 ELECTROCARDIOLOGY	67,522	5,735	0	0	73,257	69.00	
69.02 06902 SLEEP LAB	44,700	8,777	0	0	53,477	69.02	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	572,545	55,356	0	24,500	652,401	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	490,459	21,270	0	54,878	566,607	73.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00	
90.00 09000 CLINIC	0	0	0	0	0	90.00	
91.00 09100 EMERGENCY	1,165,535	197,988	0	319,761	1,683,284	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00	
99.10 09910 CORF	0	0	0	0	0	99.10	
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00	
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00	
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00	
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00	
112.00 08600 OTHER ORGAN ACQUISITION	0	0	0	0	0	112.00	
113.00 11300 INTEREST EXPENSE	0	0	0	0	0	113.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	14,048,122	1,866,183	0	1,475,075	14,021,592	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,288	0	0	12,288	190.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	108,575	0	0	14,242	122,817	192.00	
200.00	Cross Foot Adjustments					200.00	
201.00	Negative Cost Centers					201.00	
202.00	TOTAL (sum lines 118-201)	14,156,697	1,878,471	0	1,489,317	14,156,697	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151300

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet B  
Part I  
Date/Time Prepared:  
9/30/2013 11:06 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,193,335				5.00
7.00	00700	OPERATION OF PLANT	183,526	1,184,552			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	25,786	0	166,432		8.00
9.00	00900	HOUSEKEEPING	40,657	9,746	12,847	285,009	9.00
10.00	01000	DIETARY	19,453	38,235	431	9,276	173,500
11.00	01100	CAFETERIA	64,684	32,382	492	7,856	0
13.00	01300	NURSING ADMINISTRATION	50,501	19,491	0	4,729	0
16.00	01600	MEDICAL RECORDS & LIBRARY	72,500	48,831	0	11,846	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	252,811	315,133	47,336	76,452	173,500
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	2,961	7,528	254	1,826	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	277,274	212,727	50,248	51,608	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,814	0	331	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	172,356	81,110	16,306	19,677	0
57.00	05700	CT SCAN	68,750	15,340	0	3,722	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	55,530	3,687	0	894	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	246,631	62,135	0	15,074	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	990	0	0	0	0
66.00	06600	PHYSICAL THERAPY	76,423	72,602	10,164	17,613	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	587	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	13,431	5,053	600	1,226	0
69.02	06902	SLEEP LAB	9,804	7,735	361	1,876	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	119,610	48,779	0	11,834	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	103,881	18,743	0	4,547	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	308,605	174,467	24,894	42,326	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
112.00	08600	OTHER ORGAN ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,168,565	1,173,724	164,264	282,382	173,500
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,253	10,828	0	2,627	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	22,517	0	2,168	0	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	2,193,335	1,184,552	166,432	285,009	173,500

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151300

Period:  
From 05/01/2012  
To 04/30/2013

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		11.00	13.00	16.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	458,225					11.00
13.00	01300		369,748				13.00
16.00	01600	38,376	0	566,995			16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	83,530	116,398	62,454	2,506,548	0	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	1,844	3,466	2,700	36,730	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	70,614	132,703	117,114	2,424,655	0	50.00
52.00	05200	2,400	4,509	3,469	22,419	0	52.00
54.00	05400	49,789	0	52,087	1,331,425	0	54.00
57.00	05700	6,508	0	58,760	528,073	0	57.00
58.00	05800	5,417	0	21,391	389,800	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	65,164	0	113,758	1,847,990	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	0	0	179	6,570	0	65.00
66.00	06600	23,863	0	23,568	641,073	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	271	4,058	0	68.00
69.00	06900	0	0	13,586	107,153	0	69.00
69.02	06902	0	0	4,168	77,421	0	69.02
70.00	07000	0	0	0	0	0	70.00
71.00	07100	16,959	0	25,929	875,512	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	13,492	0	32,231	739,501	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	59,959	112,672	35,330	2,441,537	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
112.00	08600	0	0	0	0	0	112.00
113.00	11300	0	0	0	0	0	113.00
118.00		457,491	369,748	566,995	13,980,465	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	27,996	0	190.00
192.00	19200	734	0	0	148,236	0	192.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		458,225	369,748	566,995	14,156,697	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151300

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To 04/30/2013

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Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000 ADULTS & PEDIATRICS	2,506,548	30.00
31.00	03100 INTENSIVE CARE UNIT	0	31.00
32.00	03200 CORONARY CARE UNIT	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	34.00
41.00	04100 SUBPROVIDER - IRF	0	41.00
42.00	04200 SUBPROVIDER	0	42.00
43.00	04300 NURSERY	36,730	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000 OPERATING ROOM	2,424,655	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	22,419	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,331,425	54.00
57.00	05700 CT SCAN	528,073	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	389,800	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	59.00
60.00	06000 LABORATORY	1,847,990	60.00
60.01	06001 BLOOD LABORATORY	0	60.01
65.00	06500 RESPIRATORY THERAPY	6,570	65.00
66.00	06600 PHYSICAL THERAPY	641,073	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	67.00
68.00	06800 SPEECH PATHOLOGY	4,058	68.00
69.00	06900 ELECTROCARDIOLOGY	107,153	69.00
69.02	06902 SLEEP LAB	77,421	69.02
70.00	07000 ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	875,512	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	739,501	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00	08800 RURAL HEALTH CLINIC	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000 CLINIC	0	90.00
91.00	09100 EMERGENCY	2,441,537	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
95.00	09500 AMBULANCE SERVICES	0	95.00
99.10	09910 CORF	0	99.10
101.00	10100 HOME HEALTH AGENCY	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
109.00	10900 PANCREAS ACQUISITION	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	110.00
111.00	11100 ISLET ACQUISITION	0	111.00
112.00	08600 OTHER ORGAN ACQUISITION	0	112.00
113.00	11300 INTEREST EXPENSE	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	13,980,465	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	27,996	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	148,236	192.00
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	14,156,697	202.00

COST ALLOCATION STATISTICS

Provider CCN: 151300

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet Non-CMS W  
Date/Time Prepared:  
9/30/2013 11:06 am

Cost Center Description		Statistics Code	Statistics Description		
		1.00	2.00		
GENERAL SERVICE COST CENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1	SQUARE	FEET	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1	SQUARE	FEET	2.00
4.00	EMPLOYEE BENEFITS	S	GROSS	SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-3	ACCUM.	COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE	FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	6	POUNDS	OF LAUNDRY	8.00
9.00	HOUSEKEEPING	1	SQUARE	FEET	9.00
10.00	DIETARY	7	MEALS	SERVED	10.00
11.00	CAFETERIA	8	FTE HRS		11.00
13.00	NURSING ADMINISTRATION	10	DI RECT	NRSING HRS	13.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS	CHARGES	16.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151300

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet B  
Part II  
Date/Time Prepared:  
9/30/2013 11:06 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	2.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS	0	6,495	0	6,495	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	190,761	0	190,761	5.00
7.00 00700	OPERATION OF PLANT	0	336,963	0	336,963	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	11,059	0	11,059	9.00
10.00 01000	DIETARY	0	43,389	0	43,389	10.00
11.00 01100	CAFETERIA	0	36,748	0	36,748	11.00
13.00 01300	NURSING ADMINISTRATION	0	22,119	0	22,119	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	55,414	0	55,414	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	357,621	0	357,621	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	0	8,543	0	8,543	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	241,407	0	241,407	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	92,045	0	92,045	54.00
57.00 05700	CT SCAN	0	17,408	0	17,408	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	4,184	0	4,184	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	0	70,511	0	70,511	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	82,390	0	82,390	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	5,735	0	5,735	69.00
69.02 06902	SLEEP LAB	0	8,777	0	8,777	69.02
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	55,356	0	55,356	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	21,270	0	21,270	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	197,988	0	197,988	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
99.10 09910	CORF	0	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	111.00
112.00 08600	OTHER ORGAN ACQUISITION	0	0	0	0	112.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,866,183	0	1,866,183	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,288	0	12,288	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0		0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,878,471	0	1,878,471	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151300	Period: From 05/01/2012 To 04/30/2013	Worksheet B Part II Date/Time Prepared: 9/30/2013 11:06 am		
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
		5.00	7.00	8.00	9.00	10.00
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	191,624			5.00
7.00	00700	OPERATION OF PLANT	16,034	353,181		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,253	0	2,253	8.00
9.00	00900	HOUSEKEEPING	3,552	2,906	174	17,852
10.00	01000	DIETARY	1,700	11,400	6	581
11.00	01100	CAFETERIA	5,651	9,655	7	492
13.00	01300	NURSING ADMINISTRATION	4,412	5,811	0	296
16.00	01600	MEDICAL RECORDS & LIBRARY	6,334	14,559	0	742
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	22,088	93,958	641	4,788
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0
32.00	03200	CORONARY CARE UNIT	0	0	0	0
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0
43.00	04300	NURSERY	259	2,245	3	114
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	24,225	63,426	680	3,233
52.00	05200	DELIVERY ROOM & LABOR ROOM	159	0	4	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,059	24,183	221	1,233
57.00	05700	CT SCAN	6,007	4,574	0	233
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,852	1,099	0	56
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0
60.00	06000	LABORATORY	21,548	18,526	0	944
60.01	06001	BLOOD LABORATORY	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	87	0	0	0
66.00	06600	PHYSICAL THERAPY	6,677	21,647	138	1,103
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	51	0	0	0
69.00	06900	ELECTROCARDIOLOGY	1,173	1,507	8	77
69.02	06902	SLEEP LAB	857	2,306	5	118
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,450	14,544	0	741
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	9,076	5,588	0	285
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0
90.00	09000	CLINIC	0	0	0	0
91.00	09100	EMERGENCY	26,956	52,018	337	2,651
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	AMBULANCE SERVICES	0	0	0	0
99.10	09910	CORF	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0
112.00	08600	OTHER ORGAN ACQUISITION	0	0	0	0
113.00	11300	INTEREST EXPENSE	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	189,460	349,952	2,224	17,687
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	197	3,229	0	165
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,967	0	29	0
200.00		Cross Foot Adjustments	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	191,624	353,181	2,253	17,852

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151300

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet B  
Part II  
Date/Time Prepared:  
9/30/2013 11:06 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		11.00	13.00	16.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	52,744	35,099				13.00
16.00	01600	4,417	0	81,699			16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	9,615	11,049	8,999	566,641	0	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	212	329	389	12,099	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	8,128	12,597	16,873	371,228	0	50.00
52.00	05200	276	428	500	1,374	0	52.00
54.00	05400	5,731	0	7,506	146,439	0	54.00
57.00	05700	749	0	8,467	37,493	0	57.00
58.00	05800	624	0	3,082	13,947	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	7,501	0	16,392	135,950	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	0	0	26	113	0	65.00
66.00	06600	2,747	0	3,396	118,377	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	39	90	0	68.00
69.00	06900	0	0	1,958	10,458	0	69.00
69.02	06902	0	0	601	12,664	0	69.02
70.00	07000	0	0	0	0	0	70.00
71.00	07100	1,952	0	3,736	86,886	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	1,553	0	4,644	42,655	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	6,902	10,696	5,091	304,036	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
112.00	08600	0	0	0	0	0	112.00
113.00	11300	0	0	0	0	0	113.00
118.00		52,660	35,099	81,699	1,860,450	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	15,879	0	190.00
192.00	19200	84	0	0	2,142	0	192.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		52,744	35,099	81,699	1,878,471	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151300	Period: From 05/01/2012 To 04/30/2013	Worksheet B Part II Date/Time Prepared: 9/30/2013 11:06 am
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Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000 ADULTS & PEDIATRICS	566,641	30.00
31.00	03100 INTENSIVE CARE UNIT	0	31.00
32.00	03200 CORONARY CARE UNIT	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	34.00
41.00	04100 SUBPROVIDER - IRF	0	41.00
42.00	04200 SUBPROVIDER	0	42.00
43.00	04300 NURSERY	12,099	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000 OPERATING ROOM	371,228	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,374	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	146,439	54.00
57.00	05700 CT SCAN	37,493	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	13,947	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	59.00
60.00	06000 LABORATORY	135,950	60.00
60.01	06001 BLOOD LABORATORY	0	60.01
65.00	06500 RESPIRATORY THERAPY	113	65.00
66.00	06600 PHYSICAL THERAPY	118,377	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	67.00
68.00	06800 SPEECH PATHOLOGY	90	68.00
69.00	06900 ELECTROCARDIOLOGY	10,458	69.00
69.02	06902 SLEEP LAB	12,664	69.02
70.00	07000 ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	86,886	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	42,655	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00	08800 RURAL HEALTH CLINIC	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000 CLINIC	0	90.00
91.00	09100 EMERGENCY	304,036	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
95.00	09500 AMBULANCE SERVICES	0	95.00
99.10	09910 CORF	0	99.10
101.00	10100 HOME HEALTH AGENCY	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
109.00	10900 PANCREAS ACQUISITION	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	110.00
111.00	11100 ISLET ACQUISITION	0	111.00
112.00	08600 OTHER ORGAN ACQUISITION	0	112.00
113.00	11300 INTEREST EXPENSE		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,860,450	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,879	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	2,142	192.00
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	1,878,471	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151300

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet B-1  
Date/Time Prepared:  
9/30/2013 11:06 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	64,204					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		64,204				2.00
4.00 00400	EMPLOYEE BENEFITS	222	222	6,068,014			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	6,520	6,520	806,651	-2,193,335	11,963,362	5.00
7.00 00700	OPERATION OF PLANT	11,517	11,517	171,959	0	1,001,026	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	140,646	8.00
9.00 00900	HOUSEKEEPING	378	378	150,718	0	221,759	9.00
10.00 01000	DIETARY	1,483	1,483	30,263	0	106,105	10.00
11.00 01100	CAFETERIA	1,256	1,256	178,702	0	352,811	11.00
13.00 01300	NURSING ADMINISTRATION	756	756	194,054	0	275,451	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,894	1,894	217,444	0	395,442	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	12,223	12,223	722,986	0	1,378,934	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	292	292	5,053	0	16,151	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	8,251	8,251	616,351	0	1,512,367	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	6,573	0	9,896	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,146	3,146	431,293	0	940,100	54.00
57.00 05700	CT SCAN	595	595	51,268	0	374,993	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	143	143	46,550	0	302,881	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	2,410	2,410	493,319	0	1,345,228	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	5,401	65.00
66.00 06600	PHYSICAL THERAPY	2,816	2,816	260,573	0	416,840	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	3,200	68.00
69.00 06900	ELECTROCARDIOLOGY	196	196	0	0	73,257	69.00
69.02 06902	SLEEP LAB	300	300	0	0	53,477	69.02
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,892	1,892	99,821	0	652,401	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	727	727	223,593	0	566,607	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000	CLINIC	0	0	0	0	0	90.00
91.00 09100	EMERGENCY	6,767	6,767	1,302,815	0	1,683,284	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10 09910	CORF	0	0	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0	111.00
112.00 08600	OTHER ORGAN ACQUISITION	0	0	0	0	0	112.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	63,784	63,784	6,009,986	-2,193,335	11,828,257	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	420	420	0	0	12,288	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	58,028	0	122,817	192.00
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)	1,878,471	0	1,489,317		2,193,335	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	29.257850	0.000000	0.245437		0.183338	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			6,495		191,624	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001070		0.016018	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151300

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet B-1

Date/Time Prepared:  
9/30/2013 11:06 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE HRS)	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	45,945				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	21,648			8.00
9.00	00900	HOUSEKEEPING	378	1,671	45,567		9.00
10.00	01000	DIETARY	1,483	56	1,483	100	10.00
11.00	01100	CAFETERIA	1,256	64	1,256	0	11.00
13.00	01300	NURSING ADMINISTRATION	756	0	756	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,894	0	1,894	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	12,223	6,157	12,223	100	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	292	33	292	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	8,251	6,536	8,251	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	43	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,146	2,121	3,146	0	54.00
57.00	05700	CT SCAN	595	0	595	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	143	0	143	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	2,410	0	2,410	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,816	1,322	2,816	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	196	78	196	0	69.00
69.02	06902	SLEEP LAB	300	47	300	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,892	0	1,892	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	727	0	727	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	6,767	3,238	6,767	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
112.00	08600	OTHER ORGAN ACQUISITION	0	0	0	0	112.00
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	45,525	21,366	45,147	100	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	420	0	420	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	282	0	0	192.00
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)	1,184,552	166,432	285,009	173,500	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	25.781957	7.688101	6.254724	1.735.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	353,181	2,253	17,852	57,108	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.687039	0.104074	0.391775	571.080000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151300

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet B-1  
Date/Time Prepared:  
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Cost Center Description		NURSING ADMINISTRATION  (DIRECT NURSING HRS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		13.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100			1.00
2.00	00200			2.00
4.00	00400			4.00
5.00	00500			5.00
7.00	00700			7.00
8.00	00800			8.00
9.00	00900			9.00
10.00	01000			10.00
11.00	01100			11.00
13.00	01300	59,529		13.00
16.00	01600	0	27,761,078	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	18,740	3,057,885	30.00
31.00	03100	0	0	31.00
32.00	03200	0	0	32.00
33.00	03300	0	0	33.00
34.00	03400	0	0	34.00
41.00	04100	0	0	41.00
42.00	04200	0	0	42.00
43.00	04300	558	132,211	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	21,365	5,733,990	50.00
52.00	05200	726	169,842	52.00
54.00	05400	0	2,550,292	54.00
57.00	05700	0	2,877,009	57.00
58.00	05800	0	1,047,339	58.00
59.00	05900	0	0	59.00
60.00	06000	0	5,569,821	60.00
60.01	06001	0	0	60.01
65.00	06500	0	8,740	65.00
66.00	06600	0	1,153,915	66.00
67.00	06700	0	0	67.00
68.00	06800	0	13,285	68.00
69.00	06900	0	665,192	69.00
69.02	06902	0	204,050	69.02
70.00	07000	0	0	70.00
71.00	07100	0	1,269,560	71.00
72.00	07200	0	0	72.00
73.00	07300	0	1,578,115	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800	0	0	88.00
89.00	08900	0	0	89.00
90.00	09000	0	0	90.00
91.00	09100	18,140	1,729,832	91.00
92.00	09200			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500	0	0	95.00
99.10	09910	0	0	99.10
101.00	10100	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
109.00	10900	0	0	109.00
110.00	11000	0	0	110.00
111.00	11100	0	0	111.00
112.00	08600	0	0	112.00
113.00	11300			113.00
118.00		59,529	27,761,078	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	0	0	190.00
192.00	19200	0	0	192.00
200.00				200.00
201.00				201.00
202.00		369,748	566,995	202.00
203.00		6.211225	0.020424	203.00
204.00		35,099	81,699	204.00
205.00		0.589612	0.002943	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151300

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet C  
Part I  
Date/Time Prepared:  
9/30/2013 11:06 am

		Title XVIII		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		2,506,548	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	0	0	31.00
32.00	03200 CORONARY CARE UNIT		0	0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT		0	0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT		0	0	0	34.00
41.00	04100 SUBPROVIDER - IRF		0	0	0	41.00
42.00	04200 SUBPROVIDER		0	0	0	42.00
43.00	04300 NURSERY		36,730	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		2,424,655	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		22,419	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		1,331,425	0	0	54.00
57.00	05700 CT SCAN		528,073	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		389,800	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	06000 LABORATORY		1,847,990	0	0	60.00
60.01	06001 BLOOD LABORATORY		0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	6,570	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	641,073	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	4,058	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY		107,153	0	0	69.00
69.02	06902 SLEEP LAB		77,421	0	0	69.02
70.00	07000 ELECTROENCEPHALOGRAPHY		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		875,512	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		739,501	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
90.00	09000 CLINIC		0	0	0	90.00
91.00	09100 EMERGENCY		2,441,537	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		454,145	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES		0	0	0	95.00
99.10	09910 CORF		0	0	0	99.10
101.00	10100 HOME HEALTH AGENCY		0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00	10900 PANCREAS ACQUISITION		0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION		0	0	0	110.00
111.00	11100 ISLET ACQUISITION		0	0	0	111.00
112.00	08600 OTHER ORGAN ACQUISITION		0	0	0	112.00
113.00	11300 INTEREST EXPENSE		0	0	0	113.00
200.00	Subtotal (see instructions)		14,434,610	0	0	200.00
201.00	Less Observation Beds		454,145	0	0	201.00
202.00	Total (see instructions)		13,980,465	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151300

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet C  
Part I  
Date/Time Prepared:  
9/30/2013 11:06 am

		Title XVIII			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	2,586,841		2,586,841		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
32.00	03200	CORONARY CARE UNIT	0		0		32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0		34.00
41.00	04100	SUBPROVIDER - I RF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	132,211		132,211		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	1,616,396	4,117,594	5,733,990	0.422857	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	169,842	0	169,842	0.131999	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	105,612	2,444,680	2,550,292	0.522068	54.00
57.00	05700	CT SCAN	195,598	2,681,411	2,877,009	0.183549	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	43,040	1,004,299	1,047,339	0.372181	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	597,742	4,972,079	5,569,821	0.331786	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	2,673	6,067	8,740	0.751716	65.00
66.00	06600	PHYSICAL THERAPY	411,208	742,707	1,153,915	0.555563	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	12,501	784	13,285	0.305457	68.00
69.00	06900	ELECTROCARDIOLOGY	84,790	580,402	665,192	0.161086	69.00
69.02	06902	SLEEP LAB	0	204,050	204,050	0.379422	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	716,222	553,338	1,269,560	0.689618	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	858,782	719,333	1,578,115	0.468598	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	49,610	1,680,222	1,729,832	1.411430	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	639	470,405	471,044	0.964124	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
112.00	08600	OTHER ORGAN ACQUISITION	0	0	0		112.00
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	7,583,707	20,177,371	27,761,078		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	7,583,707	20,177,371	27,761,078		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151300	Period: From 05/01/2012 To 04/30/2013	Worksheet C Part I Date/Time Prepared: 9/30/2013 11:06 am
		Title XVII I	Hospital	Cost
Cost Center Description		PPS Inpatient Ratio		
INPATIENT ROUTINE SERVICE COST CENTERS		11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
32.00	03200 CORONARY CARE UNIT			32.00
33.00	03300 BURN INTENSIVE CARE UNIT			33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT			34.00
41.00	04100 SUBPROVIDER - I RF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
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
69.02	06902 SLEEP LAB	0.000000		69.02
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
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
99.10	09910 CORF			99.10
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
109.00	10900 PANCREAS ACQUISITION			109.00
110.00	11000 INTESTINAL ACQUISITION			110.00
111.00	11100 ISLET ACQUISITION			111.00
112.00	08600 OTHER ORGAN ACQUISITION			112.00
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 ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151300	Period: From 05/01/2012 To 04/30/2013	Worksheet D Part II Date/Time Prepared: 9/30/2013 11:06 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	371,228	5,733,990	0.064742	380,271	24,620	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,374	169,842	0.008090	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	146,439	2,550,292	0.057420	50,794	2,917	54.00
57.00	05700 CT SCAN	37,493	2,877,009	0.013032	84,337	1,099	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	13,947	1,047,339	0.013317	36,450	485	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	135,950	5,569,821	0.024408	232,034	5,663	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	113	8,740	0.012929	1,715	22	65.00
66.00	06600 PHYSICAL THERAPY	118,377	1,153,915	0.102587	105,148	10,787	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	90	13,285	0.006775	8,127	55	68.00
69.00	06900 ELECTROCARDIOLOGY	10,458	665,192	0.015722	26,547	417	69.00
69.02	06902 SLEEP LAB	12,664	204,050	0.062063	0	0	69.02
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	86,886	1,269,560	0.068438	230,934	15,805	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	42,655	1,578,115	0.027029	337,405	9,120	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	304,036	1,729,832	0.175760	4,744	834	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	471,044	0.000000	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	1,281,710	25,042,026		1,498,506	71,824	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151300

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet D  
Part IV  
Date/Time Prepared:  
9/30/2013 11:06 am

Cost Center Description		Title XVIII				Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)			
		1.00	2.00	3.00	4.00	5.00			
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
69.02	06902	SLEEP LAB	0	0	0	0	0	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151300

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet D  
Part IV  
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Cost		
		6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	5,733,990	0.000000	0.000000	380,271	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	169,842	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,550,292	0.000000	0.000000	50,794	54.00
57.00	05700	CT SCAN	0	2,877,009	0.000000	0.000000	84,337	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,047,339	0.000000	0.000000	36,450	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	5,569,821	0.000000	0.000000	232,034	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	8,740	0.000000	0.000000	1,715	65.00
66.00	06600	PHYSICAL THERAPY	0	1,153,915	0.000000	0.000000	105,148	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	13,285	0.000000	0.000000	8,127	68.00
69.00	06900	ELECTROCARDIOLOGY	0	665,192	0.000000	0.000000	26,547	69.00
69.02	06902	SLEEP LAB	0	204,050	0.000000	0.000000	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,269,560	0.000000	0.000000	230,934	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	1,578,115	0.000000	0.000000	337,405	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	1,729,832	0.000000	0.000000	4,744	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	471,044	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	25,042,026			1,498,506	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151300

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet D  
Part IV  
Date/Time Prepared:  
9/30/2013 11:06 am

Cost Center Description			Title XVIII			Hospital		Cost
			Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
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
69.02	06902	SLEEP LAB	0	0	0	0	0	69.02
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
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151300

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet D  
Part IV  
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Cost Center Description		PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost		
		23.00	24.00		
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700 CT SCAN	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000 LABORATORY	0	0		60.00
60.01	06001 BLOOD LABORATORY	0	0		60.01
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
69.02	06902 SLEEP LAB	0	0		69.02
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
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0	0		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000 CLINIC	0	0		90.00
91.00	09100 EMERGENCY	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151300	Period: From 05/01/2012 To 04/30/2013	Worksheet D Part V Date/Time Prepared: 9/30/2013 11:06 am
	Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0.422857	0	877,834	0	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.131999	0	0	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.522068	0	520,794	0	0
57.00 05700 CT SCAN	0.183549	0	869,327	0	0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.372181	0	224,896	0	0
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00 06000 LABORATORY	0.331786	0	1,820,075	0	0
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0
65.00 06500 RESPIRATORY THERAPY	0.751716	0	1,701	0	0
66.00 06600 PHYSICAL THERAPY	0.555563	0	274,748	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0
68.00 06800 SPEECH PATHOLOGY	0.305457	0	516	0	0
69.00 06900 ELECTROCARDIOLOGY	0.161086	0	192,040	0	0
69.02 06902 SLEEP LAB	0.379422	0	61,215	0	0
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.689618	0	127,376	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.468598	0	354,502	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0
90.00 09000 CLINIC	0.000000	0	0	0	0
91.00 09100 EMERGENCY	1.411430	0	511,409	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.964124	0	197,892	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00 09500 AMBULANCE SERVICES	0.000000		0		95.00
200.00 Subtotal (see instructions)		0	6,034,325	0	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	6,034,325	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151300	Period: From 05/01/2012 To 04/30/2013	Worksheet D Part V Date/Time Prepared: 9/30/2013 11:06 am
	Title XVIII	Hospital	Cost

Cost Center Description	Costs		Hospital	Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	371,198	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	271,890	0		54.00
57.00 05700 CT SCAN	159,564	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	83,702	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	603,875	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
65.00 06500 RESPIRATORY THERAPY	1,279	0		65.00
66.00 06600 PHYSICAL THERAPY	152,640	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	158	0		68.00
69.00 06900 ELECTROCARDIOLOGY	30,935	0		69.00
69.02 06902 SLEEP LAB	23,226	0		69.02
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	87,841	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	166,119	0		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	721,818	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	190,792	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00 09500 AMBULANCE SERVICES	0	0		95.00
200.00 Subtotal (see instructions)	2,865,037	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)	2,865,037	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151300 Component CCN: 15Z300	Period: From 05/01/2012 To 04/30/2013	Worksheet D Part V Date/Time Prepared: 9/30/2013 11:06 am
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0.422857	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.131999	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.522068	0	0	0	54.00
57.00	05700 CT SCAN	0.183549	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.372181	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	06000 LABORATORY	0.331786	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.751716	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.555563	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.305457	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.161086	0	0	0	69.00
69.02	06902 SLEEP LAB	0.379422	0	0	0	69.02
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.689618	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.468598	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0.000000				88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00	09000 CLINIC	0.000000	0	0	0	90.00
91.00	09100 EMERGENCY	1.411430	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.964124	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES	0.000000		0		95.00
200.00	Subtotal (see instructions)		0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151300

Period:

Worksheet D

Component CCN: 15Z300

From 05/01/2012

Part V

To 04/30/2013

Date/Time Prepared:

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
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
69.02	06902	SLEEP LAB	0	0	69.02
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
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151300	Period: From 05/01/2012 To 04/30/2013	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 9/30/2013 11:06 am
Cost Center Description			Cost	
			1.00	
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,994	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,534	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,197	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		217	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)		109	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		109	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)		25	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		596	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)		217	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)		109	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
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,506,548	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)		439,321	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,067,227	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		1,578,077	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		1,578,077	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.309966	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)		1,318.36	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)		2,067,227	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,347.61	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		803,176	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)		803,176	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151300		Period: From 05/01/2012 To 04/30/2013		Worksheet D-1 Date/Time Prepared: 9/30/2013 11:06 am		
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Hospital Cost		
Intensive Care Type Inpatient Hospital Units		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0 42.00		
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0 43.00		
44.00	CORONARY CARE UNIT	0	0	0.00	0	0 44.00		
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0 45.00		
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0 46.00		
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00		
Cost Center Description							1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						683,872 48.00	
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						1,487,048 49.00	
<b>PASS THROUGH COST ADJUSTMENTS</b>								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0 50.00	
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0 51.00	
52.00	Total Program excludable cost (sum of lines 50 and 51)						0 52.00	
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0 53.00	
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>								
54.00	Program discharges						0 54.00	
55.00	Target amount per discharge						0.00 55.00	
56.00	Target amount (line 54 x line 55)						0 56.00	
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0 57.00	
58.00	Bonus payment (see instructions)						0 58.00	
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00 59.00	
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00 60.00	
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0 61.00	
62.00	Relief payment (see instructions)						0 62.00	
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0 63.00	
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						292,431 64.00	
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						146,889 65.00	
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						439,320 66.00	
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0 67.00	
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0 68.00	
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0 69.00	
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>								
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00	
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00	
72.00	Program routine service cost (line 9 x line 71)						72.00	
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00	
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00	
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00	
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00	
77.00	Program capital-related costs (line 9 x line 76)						77.00	
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00	
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00	
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00	
81.00	Inpatient routine service cost per diem limitation						81.00	
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00	
83.00	Reasonable inpatient routine service costs (see instructions)						83.00	
84.00	Program inpatient ancillary services (see instructions)						84.00	
85.00	Utilization review - physician compensation (see instructions)						85.00	
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00	
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>								
87.00	Total observation bed days (see instructions)						337 87.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,347.61 88.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)						454,145 89.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151300		Period: From 05/01/2012 To 04/30/2013		Worksheet D-1 Date/Time Prepared: 9/30/2013 11:06 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151300	Period: From 05/01/2012 To 04/30/2013	Worksheet D-3 Date/Time Prepared: 9/30/2013 11:06 am
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		878,296		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
32.00	03200 CORONARY CARE UNIT		0		32.00
33.00	03300 BURN INTENSIVE CARE UNIT		0		33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT		0		34.00
41.00	04100 SUBPROVIDER - I RF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.422857	380,271	160,800	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.131999	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.522068	50,794	26,518	54.00
57.00	05700 CT SCAN	0.183549	84,337	15,480	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.372181	36,450	13,566	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.331786	232,034	76,986	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.751716	1,715	1,289	65.00
66.00	06600 PHYSICAL THERAPY	0.555563	105,148	58,416	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.305457	8,127	2,482	68.00
69.00	06900 ELECTROCARDIOLOGY	0.161086	26,547	4,276	69.00
69.02	06902 SLEEP LAB	0.379422	0	0	69.02
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.689618	230,934	159,256	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.468598	337,405	158,107	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	1.411430	4,744	6,696	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.964124	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		1,498,506	683,872	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)		1,498,506		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151300 Component CCN: 15Z300	Period: From 05/01/2012 To 04/30/2013	Worksheet D-3 Date/Time Prepared: 9/30/2013 11:06 am
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
32.00	03200 CORONARY CARE UNIT		0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT		0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT		0	34.00
41.00	04100 SUBPROVIDER - I RF		0	41.00
42.00	04200 SUBPROVIDER		0	42.00
43.00	04300 NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.422857	2,914	1,232 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.131999	0	0 52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.522068	7,578	3,956 54.00
57.00	05700 CT SCAN	0.183549	3,684	676 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.372181	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000 LABORATORY	0.331786	50,277	16,681 60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0 60.01
65.00	06500 RESPIRATORY THERAPY	0.751716	759	571 65.00
66.00	06600 PHYSICAL THERAPY	0.555563	187,891	104,385 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.305457	3,053	933 68.00
69.00	06900 ELECTROCARDIOLOGY	0.161086	7,366	1,187 69.00
69.02	06902 SLEEP LAB	0.379422	0	0 69.02
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.689618	3,754	2,589 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.468598	106,803	50,048 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0.000000		0 88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0 89.00
90.00	09000 CLINIC	0.000000	0	0 90.00
91.00	09100 EMERGENCY	1.411430	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.964124	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES			
200.00	Total (sum of lines 50-94 and 96-98)		374,079	182,258 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net Charges (line 200 minus line 201)		374,079	182,258 202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151300	Period: From 05/01/2012 To 04/30/2013	Worksheet E Part B Date/Time Prepared: 9/30/2013 11:06 am
		Title XVII	Hospital	Cost
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			2,865,037 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)			2,865,037 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
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
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			2,893,687 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
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)			23,594 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			832,854 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			2,037,239 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			2,037,239 30.00
31.00	Primary payer payments			2,046 31.00
32.00	Subtotal (line 30 minus line 31)			2,035,193 32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			75,244 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			75,244 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			61,482 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			2,110,437 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	AB Re-billing demo amount (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			2,110,437 40.00
41.00	Interim payments			1,979,148 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)			131,289 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			108,120 44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00
				Overrides
				1.00
<b>WORKSHEET OVERRIDE VALUES</b>				
112.00	Override of Ancillary service charges (line 12)			0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151300

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet E-1  
Part I  
Date/Time Prepared:  
9/30/2013 11:06 am

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,361,533		1,937,648	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	11/09/2012	41,500	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		41,500	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)		1,361,533		1,979,148	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		131,289	6.01	
6.02	SETTLEMENT TO PROGRAM		36,702		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,324,831		2,110,437	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151300  
Component CCN: 15Z300

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet E-1  
Part I  
Date/Time Prepared:  
9/30/2013 11:06 am

Title XVIII Swing Beds - SNF Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		672,740		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)		672,740		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		47,114		0	6.02
7.00	Total Medicare program liability (see instructions)		625,626		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 151300

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet E-1  
Part II  
Date/Time Prepared:  
9/30/2013 11:06 am

		Title XVIII	Hospital	Cost	
				1.00	
<b>TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS</b>					
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			436	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			596	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			0	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			1,197	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			27,761,078	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			751,170	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)			0	8.00
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>					
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30.00
31.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)			0	32.00
				<b>Overrides</b>	
				1.00	
<b>CONTRACTOR OVERRIDES</b>					
108.00	Override of HIT payment				108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151300

Period:

Worksheet E-2

Component CCN: 15Z300

From 05/01/2012

Date/Time Prepared:

To 04/30/2013

9/30/2013 11:06 am

		Title XVIII		Swing Beds - SNF	
		Cost			
		Part A	Part B		
		1.00	2.00		
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient routine services - swing bed-SNF (see instructions)	443,713	0	1.00	
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00	
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	184,081	0	3.00	
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00	
5.00	Program days	326	326	5.00	
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00	
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00	
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	627,794	0	8.00	
9.00	Primary payer payments (see instructions)	0	0	9.00	
10.00	Subtotal (line 8 minus line 9)	627,794	0	10.00	
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00	
12.00	Subtotal (line 10 minus line 11)	627,794	0	12.00	
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	2,168	0	13.00	
14.00	80% of Part B costs (line 12 x 80%)		0	14.00	
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	625,626	0	15.00	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00	
17.00	Reimbursable bad debts (see instructions)	0	0	17.00	
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00	
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	625,626	0	19.00	
20.00	Interim payments	672,740	0	20.00	
21.00	Tentative settlement (for contractor use only)	0	0	21.00	
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	-47,114	0	22.00	
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2	23,452	0	23.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151300	Period: From 05/01/2012 To 04/30/2013	Worksheet E-3 Part V Date/Time Prepared: 9/30/2013 11:06 am
		Title XVIII	Hospital	Cost
				1.00
<b>PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)</b>				
1.00	Inpatient services			1,487,048 1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 thru 3)			1,487,048 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1,501,918 6.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
<b>Customary charges</b>				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 17.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			1,501,918 19.00
20.00	Deductibles (exclude professional component)			178,352 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			1,323,566 22.00
23.00	Coinsurance			5,780 23.00
24.00	Subtotal (line 22 minus line 23)			1,317,786 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			7,045 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			7,045 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			3,318 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1,324,831 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (line 28, plus or minus lines 29)			1,324,831 30.00
31.00	Interim payments			1,361,533 31.00
32.00	Tentative settlement (for contractor use only)			0 32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)			-36,702 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 34.00

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

Provider CCN: 151300

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet G

Date/Time Prepared:  
9/30/2013 11:06 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	1,361,948	0	0	0	1.00
2.00	Temporary investments	1,013,054	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,465,740	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-730,301	0	0	0	6.00
7.00	Inventory	125,172	0	0	0	7.00
8.00	Prepaid expenses	637,589	0	0	0	8.00
9.00	Other current assets	44,980	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)	5,918,182	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	440,039	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	17,740,106	0	0	0	15.00
16.00	Accumulated depreciation	-3,299,780	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	6,741,983	0	0	0	23.00
24.00	Accumulated depreciation	-4,528,911	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	197,824	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	17,291,261	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	23,209,443	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	751,523	0	0	0	37.00
38.00	Salaries, wages, and fees payable	629,050	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	68,353	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	946,124	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,395,050	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	16,004,781	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)	16,004,781	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	18,399,831	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	4,809,612	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)	4,809,612	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	23,209,443	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151300

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet G-1

Date/Time Prepared:  
9/30/2013 11:06 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		2,681,976		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		479,500			2.00
3.00	Total (sum of line 1 and line 2)		3,161,476		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		3,161,476		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		3,161,476		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151300

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
9/30/2013 11:06 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	2,543,988		2,543,988	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	175,064		175,064	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,719,052		2,719,052	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT	0		0	12.00
13.00	BURN INTENSIVE CARE UNIT	0		0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT	0		0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,719,052		2,719,052	17.00
18.00	Ancillary services	4,536,262	0	4,536,262	18.00
19.00	Outpatient services	0	21,559,177	21,559,177	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	0	0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,255,314	21,559,177	28,814,491	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		15,881,954		29.00
30.00	BAD DEBTS	575,351			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)		575,351		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)		16,457,305		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151300

Period:  
From 05/01/2012  
To 04/30/2013

Worksheet G-3

Date/Time Prepared:  
9/30/2013 11:06 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	28,814,491	1.00
2.00	Less contractual allowances and discounts on patients' accounts	12,843,554	2.00
3.00	Net patient revenues (line 1 minus line 2)	15,970,937	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	16,457,305	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-486,368	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	272,036	6.00
7.00	Income from investments	26,983	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	5,563	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	114,852	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	20,741	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	4,027	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC INCL EHR FUNDING	521,666	24.00
25.00	Total other income (sum of lines 6-24)	965,868	25.00
26.00	Total (line 5 plus line 25)	479,500	26.00
27.00		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)	479,500	29.00