

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 153039
Period: From 01/01/2013 To 12/31/2013
Worksheet S
Parts I-III
Date/Time Prepared: 5/29/2014 10:01 am

PART I - COST REPORT STATUS

Provider use only
1. [X] Electronically filed cost report
2. [] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Date: 5/29/2014 Time: 10:01 am

Contractor use only
5. [1] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] 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 HRH SPECIALITY HOSPITAL (153039) for the cost reporting period beginning 01/01/2013 and ending 12/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 5/29/2014 Time: 10:01 am
Eie0XbpdHcgeqFta7bss7UYzXZ1IP0
VE8ot0zkEZULnLaA3cy81yilbQ:Prz
xcPI0PssQk0AV8gw
PI: Date: 5/29/2014 Time: 10:01 am
7nyxhB5KJ9omtAHWD4OICC51:ABUV0
rtczh00dA:4NsYzoIpr.DmthFqnR33
XG5o094JmZ0wg8X0

(Signed) [Signature]
Officer or Administrator of Provider(s)
Title Administrator
Date 5-29-14

Table with columns: Title V, Title XVIII (Part A, Part B), HIT, Title XIX, and settlement amounts for various providers like Hospital, Subprovider - IPF, etc.

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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 153039	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/29/2014 10:00 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: 829 NORTH DIXON ROAD	PO Box:		1.00
2.00	City: KOKOMO	State: IN	Zip Code: 46901	2.00
			County: HOWARD	

	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 HRH SPECIALTY HOSPITAL	153039	99915	5	04/01/2004	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
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)	01/01/2013	12/31/2013	20.00
21.00	Type of Control (see instructions)	6		21.00

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

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
								1.00
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.							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.							25.00
	0	0	0	0	0	0	0	
	97	0	0	0	0	0	0	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 153039	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/29/2014 10:00 am		
		Urban/Rural S	Date of Geogr			
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0			35.00	
		Beginning:	Ending:			
		1.00	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	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N			39.00	
		V	XVII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 153039		Period: From 01/01/2013 To 12/31/2013		Worksheet S-2 Part I Date/Time Prepared: 5/29/2014 10:00 am	
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20	
					1.00		
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings							
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00	
				Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 153039	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/29/2014 10:00 am																
		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	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000														
<table border="1"> <thead> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> <th>3.00</th> <th>4.00</th> <th>5.00</th> </tr> </thead> <tbody> <tr> <td colspan="2"></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>									1.00	2.00	3.00	4.00	5.00							
		1.00	2.00	3.00	4.00	5.00														
Inpatient Psychiatric Facility PPS																				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N															
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				N	0														
Inpatient Rehabilitation Facility PPS																				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				Y															
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				N	N 0														
<table border="1"> <thead> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> <th>3.00</th> <th>4.00</th> <th>5.00</th> </tr> </thead> <tbody> <tr> <td colspan="2"></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>									1.00	2.00	3.00	4.00	5.00							
		1.00	2.00	3.00	4.00	5.00														
Long Term Care Hospital PPS																				
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N															
TEFRA Providers																				
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N															
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.																			
<table border="1"> <thead> <tr> <th colspan="2"></th> <th>V</th> <th>XIX</th> </tr> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> </tr> </thead> <tbody> <tr> <td colspan="2"></td> <td></td> <td></td> </tr> </tbody> </table>									V	XIX			1.00	2.00						
		V	XIX																	
		1.00	2.00																	
Title V and XIX Services																				
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.				N	Y														
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.				N	N														
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														
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														
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.				N	N														
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00														

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		V	XIX			
		1.00	2.00			
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. Rural Providers	0.00	0.00		97.00	
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N			105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	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	N	N	109.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N		0	115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00	
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	37,330	0	0		118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02	
119.00	DO NOT USE THIS LINE				119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N			121.00	
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 153039	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/29/2014 10:00 am			
		1.00	2.00				
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00			
		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		144.00			
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N		145.00			
				1.00			
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00			
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00			
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00			
		Part A 1.00	Part B 2.00	Title V 3.00	Title XIX 4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N		
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		
				1.00			
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N		165.00			
		Name 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5					0.00	166.00
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	N		167.00			
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			0.00			
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.00			
		Beginning 1.00		Ending 2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00			

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 153039	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/29/2014 10:00 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.			N	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Description	Part A		Part B
			Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		Y	04/02/2014	Y
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
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N
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
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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 153039	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/29/2014 10:00 am	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			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.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RONALD	HELMS		41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH NETWORK			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-355-5501	RHELMS@COMMUNITY.COM		43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	04/02/2014	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 153039

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2014 10:00 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	30	10,950	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		30	10,950	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		30	10,950	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)	115.00					23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC	99.00				0	25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		30				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 153039

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2014 10:00 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)(see instructions for col. 2 for the portion of LDP room available beds)	4,654	97	5,686			1.00
2.00 HMO and other (see instructions)	0	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	4,654	97	5,686			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)	4,654	97	5,686	0.00	140.26	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				0.00	0.00	23.00
24.00 HOSPICE	0	0	0	0.00	0.00	24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC	0	0	0	0.00	0.00	25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	140.26	27.00
28.00 Observation Bed Days		0	0			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 153039

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2014 10:00 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)(see instructions for col. 2 for the portion of LDP room available beds)		0	465	10	568	1.00
2.00	HMO and other (see instructions)			5			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	465	10	568	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)	0.00					23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC	0.00					25.00
25.10	CMHC - CORF	0.00					25.10
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 153039

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

Worksheet A
Date/Time Prepared:
5/29/2014 10:00 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	
GENERAL SERVICE COST CENTERS							
1.00	00100			0	1,315,372	1,315,372	1.00
2.00	00200			0	0	0	2.00
3.00	00300			0	0	0	3.00
4.00	00400	82,195	953,877	1,036,072	-3,845	1,032,227	4.00
5.00	00500	1,119,872	1,203,185	2,323,057	-292,367	2,030,690	5.00
7.00	00700	286,066	1,540,463	1,826,529	-917,452	909,077	7.00
8.00	00800	0	7,749	7,749	0	7,749	8.00
9.00	00900	72,712	60,559	133,271	0	133,271	9.00
10.00	01000	192,455	146,029	338,484	-111,552	226,932	10.00
11.00	01100	0	0	0	104,125	104,125	11.00
13.00	01300	88,528	13,282	101,810	0	101,810	13.00
16.00	01600	201,344	50,008	251,352	-591	250,761	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,163,447	668,159	1,831,606	-505,264	1,326,342	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	1,327	3,853	5,180	46,710	51,890	54.00
54.01	03950	0	0	0	0	0	54.01
54.02	03951	0	20	20	49,839	49,859	54.02
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	-119	-119	220,092	219,973	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	260,107	34,502	294,609	-3,078	291,531	65.00
66.00	06600	1,972,240	267,008	2,239,248	-63,324	2,175,924	66.00
67.00	06700	779,674	224,062	1,003,736	-13,696	990,040	67.00
68.00	06800	205,618	-68,368	137,250	-1,987	135,263	68.00
69.00	06900	0	0	0	4,626	4,626	69.00
71.00	07100	41,333	5,748	47,081	165,375	212,456	71.00
73.00	07300	276,456	300,715	577,171	40,140	617,311	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04950	0	0	0	0	0	93.00
93.02	04952	82,780	11,089	93,869	0	93,869	93.02
93.03	04953	380,786	147,852	528,638	-33,123	495,515	93.03
93.04	04954	0	102	102	0	102	93.04
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
96.00	09600	0	0	0	0	0	96.00
97.00	09700	0	0	0	0	0	97.00
98.00	05950	0	0	0	0	0	98.00
99.00	09900	0	0	0	0	0	99.00
99.10	09910	0	0	0	0	0	99.10
100.00	10000	0	0	0	0	0	100.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
105.00	10500	0	0	0	0	0	105.00
106.00	10600	0	0	0	0	0	106.00
107.00	10700	0	0	0	0	0	107.00
108.00	10800	0	0	0	0	0	108.00
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
113.00	11300	0	0	0	0	0	113.00
114.00	11400	0	0	0	0	0	114.00
115.00	11500	0	0	0	0	0	115.00
116.00	11600	0	0	0	0	0	116.00
118.00		7,206,940	5,569,775	12,776,715	0	12,776,715	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
200.00		7,206,940	5,569,775	12,776,715	0	12,776,715	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 153039

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

Worksheet A
Date/Time Prepared:
5/29/2014 10:00 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	1,315,372	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,032,227	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	31,888	2,062,578	5.00
7.00	00700	OPERATION OF PLANT	0	909,077	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,749	8.00
9.00	00900	HOUSEKEEPING	0	133,271	9.00
10.00	01000	DIETARY	-1,073	225,859	10.00
11.00	01100	CAFETERIA	0	104,125	11.00
13.00	01300	NURSING ADMINISTRATION	0	101,810	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-18,505	232,256	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,326,342	30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,157	57,047	54.00
54.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	54.01
54.02	03951	IMAGING CENTER	-4,827	45,032	54.02
57.00	05700	CT SCAN	1,690	1,690	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	219,973	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	291,531	65.00
66.00	06600	PHYSICAL THERAPY	-28,660	2,147,264	66.00
67.00	06700	OCCUPATIONAL THERAPY	-3,773	986,267	67.00
68.00	06800	SPEECH PATHOLOGY	0	135,263	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,626	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	212,456	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	617,311	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
93.02	04952	NEUROPSYCH	0	93,869	93.02
93.03	04953	SLEEP LAB	-34,500	461,015	93.03
93.04	04954	PHYSICIANS OFFICE	0	102	93.04
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
99.00	09900	CMHC	0	0	99.00
99.10	09910	CORF	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
105.00	10500	KIDNEY ACQUISITION	0	0	105.00
106.00	10600	HEART ACQUISITION	0	0	106.00
107.00	10700	LIVER ACQUISITION	0	0	107.00
108.00	10800	LUNG ACQUISITION	0	0	108.00
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
113.00	11300	INTEREST EXPENSE	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	115.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-52,603	12,724,112	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	PROJECT ACCESS	0	0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	-52,603	12,724,112	200.00

RECLASSIFICATIONS

Provider CCN: 153039

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

Worksheet A-6

Date/Time Prepared:
5/29/2014 10:00 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
A - Capital Insurance Costs						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	8,863		1.00
	TOTALS		0	8,863		
B - Medical Supply Expense Recl ass						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	164,809		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
	TOTALS		0	164,809		
C - Pharmaceutical Expense Recl ass						
1.00	DRUGS CHARGED TO PATIENTS	73.00		79,363		1.00
2.00						2.00
3.00			0	79,363		3.00
D - Cafeteria Salary						
1.00	CAFETERIA	11.00	59,392	0		1.00
			59,392	0		
E - Cafeteria Other						
1.00	CAFETERIA	11.00		44,733		1.00
			0	44,733		
F - Depreciation Expense						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	242,513		1.00
	TOTALS		0	242,513		
G - Equipment Rental Expense Recl ass						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	90,516		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	90,516		
H - Building Rental Expense Recl ass						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	973,480		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	973,480		
I - Plant Operations Expense						
1.00	OPERATION OF PLANT	7.00	0	30,497		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
	TOTALS		0	30,497		
J - Purchased Service Recl ass						
1.00	RADIOLOGY-DIAGNOSTIC	54.00		50,443		1.00
2.00	IMAGING CENTER	54.02		49,839		2.00
3.00	LABORATORY	60.00		220,092		3.00
4.00	ELECTROCARDIOLOGY	69.00		4,626		4.00
5.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		566		5.00
6.00	DRUGS CHARGED TO PATIENTS	73.00		2,837		6.00
			0	328,403		
500.00	Grand Total: Increases		59,392	1,963,177		500.00

RECLASSIFICATIONS

Provider CCN: 153039

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

Worksheet A-6
Date/Time Prepared:
5/29/2014 10:00 am

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - Capital Insurance Costs						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,863	12	1.00
	TOTALS		0	8,863		
B - Medical Supply Expense Recl ass						
1.00	ADULTS & PEDIATRICS	30.00	0	80,908	0	1.00
2.00	RESPIRATORY THERAPY	65.00	0	2,935	0	2.00
3.00	PHYSICAL THERAPY	66.00	0	33,817	0	3.00
4.00	OCCUPATIONAL THERAPY	67.00	0	12,687	0	4.00
5.00	SPEECH PATHOLOGY	68.00	0	1,987	0	5.00
6.00	SLEEP LAB	93.03	0	32,475	0	6.00
	TOTALS		0	164,809		
C - Pharmaceutical Expense Recl ass						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		3,154		1.00
2.00	ADULTS & PEDIATRICS	30.00		75,819		2.00
3.00	PHYSICAL THERAPY	66.00		390		3.00
			0	79,363		
D - Cafeteria Salary						
1.00	DIETARY	10.00	59,392			1.00
			59,392	0		
E - Cafeteria Other						
1.00	DIETARY	10.00		44,733		1.00
			0	44,733		
F - Depreciation Expense						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	242,513	9	1.00
	TOTALS		0	242,513		
G - Equipment Rental Expense Recl ass						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	691	10	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	8,350	0	2.00
3.00	OPERATION OF PLANT	7.00	0	7,350	0	3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	591	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	10,510	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,733	0	6.00
7.00	PHYSICAL THERAPY	66.00	0	16,988	0	7.00
8.00	DRUGS CHARGED TO PATIENTS	73.00	0	41,931	0	8.00
9.00	SLEEP LAB	93.03	0	372	0	9.00
	TOTALS		0	90,516		
H - Building Rental Expense Recl ass						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	31,930	10	1.00
2.00	OPERATION OF PLANT	7.00	0	940,599	0	2.00
3.00	PHYSICAL THERAPY	66.00	0	951	0	3.00
	TOTALS		0	973,480		
I - Plant Operations Expense						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	711	0	1.00
2.00	DIETARY	10.00	0	7,427	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	9,624	0	3.00
4.00	RESPIRATORY THERAPY	65.00	0	143	0	4.00
5.00	PHYSICAL THERAPY	66.00	0	11,178	0	5.00
6.00	OCCUPATIONAL THERAPY	67.00	0	1,009	0	6.00
7.00	DRUGS CHARGED TO PATIENTS	73.00	0	129	0	7.00
8.00	SLEEP LAB	93.03	0	276	0	8.00
	TOTALS		0	30,497		
J - Purchased Service Recl ass						
1.00	ADULTS & PEDIATRICS	30.00		328,403		1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
			0	328,403		
500.00	Grand Total: Decreases		59,392	1,963,177		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 153039

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

Worksheet A-7
Part I
Date/Time Prepared:
5/29/2014 10:00 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	90,000	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	5,079	4,284	0	4,284	4.00
5.00	Fixed Equipment	25,449	0	0	0	5.00
6.00	Movable Equipment	574,662	151,931	0	151,931	6.00
7.00	HIT designated Assets	577,844	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	1,273,034	156,215	0	156,215	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	1,273,034	156,215	0	156,215	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	90,000	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	9,363	0			4.00
5.00	Fixed Equipment	25,449	0			5.00
6.00	Movable Equipment	725,943	0			6.00
7.00	HIT designated Assets	572,000	0			7.00
8.00	Subtotal (sum of lines 1-7)	1,422,755	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	1,422,755	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 153039

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

Worksheet A-7
Part II
Date/Time Prepared:
5/29/2014 10:00 am

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

RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 153039	Period: From 01/01/2013 To 12/31/2013	Worksheet A-7 Part III Date/Time Prepared: 5/29/2014 10:00 am
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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	CAP REL COSTS-BLDG & FIXT	1,422,755	0	1,422,755	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	1,422,755	0	1,422,755	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	242,513	1,063,996	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	242,513	1,063,996	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	8,863	0	0	1,315,372	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	8,863	0	0	1,315,372	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 153039

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

Worksheet A-8

Date/Time Prepared:
5/29/2014 10:00 am

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 - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)			0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00		0	7.00
8.00 Television and radio service (chapter 21)			0		0.00		0	8.00
9.00 Parking lot (chapter 21)			0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-336,318					0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00		0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	440,794					0	12.00
13.00 Laundry and linen service			0		0.00		0	13.00
14.00 Cafeteria-employees and guests			0		0.00		0	14.00
15.00 Rental of quarters to employee and others			0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00		0	16.00
17.00 Sale of drugs to other than patients			0		0.00		0	17.00
18.00 Sale of medical records and abstracts			0		0.00		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00		0	19.00
20.00 Vending machines			0		0.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	UTILIZATION REVIEW-SNF	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		0	28.00
29.00 Physicians' assistant			0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00		0	32.00
33.00 Misc Income Account 4720	B	-3,208		ADMINISTRATIVE & GENERAL	5.00		0	33.00
33.01 Misc Income Account 4720	B	-1,786		MEDICAL RECORDS & LIBRARY	16.00		0	33.01

Provider CCN: 153039
 Period: From 01/01/2013 To 12/31/2013
 Worksheet A-8
 Date/Time Prepared: 5/29/2014 10:00 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
33.02 Misc Income Account 4700	B	-87	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03 Misc Income Account 4700	B	-3,773	OCCUPATIONAL THERAPY	67.00	0	33.03
33.04 Misc Income Account 47XX	B	-1,073	DIETARY	10.00	0	33.04
33.05 Misc Income Account 47XX	B	-16,719	MEDICAL RECORDS & LIBRARY	16.00	0	33.05
33.06 Misc Income Account 47XX	B	-23,808	PHYSICAL THERAPY	66.00	0	33.06
33.07 WS A-8 - Other Operating Revenue	B	-3,660	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08 WS A-8 - Gain Loss on Disposal of Assets	B	-38	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09 WS A-8 - Gain Loss on Disposal of Assets	B	-1,814	ADMINISTRATIVE & GENERAL	5.00	0	33.09
34.00 Charitable Contributions-Offset	A	-1,433	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01 Advertising Expense Offset	A	-26,662	ADMINISTRATIVE & GENERAL	5.00	0	34.01
34.02 Advertising Expense Offset	A	-4,852	PHYSICAL THERAPY	66.00	0	34.02
34.03 Bad Debt-Offset	A	-68,166	ADMINISTRATIVE & GENERAL	5.00	0	34.03
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-52,603				50.00

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

Provider CCN: 153039

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

Worksheet A-8-1

Date/Time Prepared:
5/29/2014 10:00 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE AND GENERAL	631,826	193,052 1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	ANCILLARY SERVICES	34,350	29,193 2.00
3.00	57.00	CT SCAN	ANCILLARY SERVICES	18,092	16,402 3.00
4.00	54.02	IMAGING CENTER	ANCILLARY SERVICES	7,055	11,882 4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			691,323	250,529 5.00

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

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

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

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

6.00	G	COMMUNITY HOWAR	60.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	MISC SERVICES				100.00

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

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

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

Provider CCN: 153039

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

Worksheet A-8-1

Date/Time Prepared:
5/29/2014 10:00 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	438,774	0		1.00
2.00	5,157	0		2.00
3.00	1,690	0		3.00
4.00	-4,827	0		4.00
5.00	440,794			5.00

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

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

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 153039

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

Worksheet A-8-2

Date/Time Prepared:
5/29/2014 10:00 am

	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	5.00	DR. A	18,000	0	0	0	0	1.00
2.00	5.00	DR. B	101,308	0	0	0	0	2.00
3.00	5.00	DR. B	50,010	0	0	0	0	3.00
4.00	5.00	DR. D	132,500	0	0	0	0	4.00
5.00	93.03	DR. E	34,500	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			336,318	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	DR. A	0	0	0	0	0	1.00
2.00	5.00	DR. B	0	0	0	0	0	2.00
3.00	5.00	DR. B	0	0	0	0	0	3.00
4.00	5.00	DR. D	0	0	0	0	0	4.00
5.00	93.03	DR. E	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	5.00	DR. A	0	0	0	18,000		1.00
2.00	5.00	DR. B	0	0	0	101,308		2.00
3.00	5.00	DR. B	0	0	0	50,010		3.00
4.00	5.00	DR. D	0	0	0	132,500		4.00
5.00	93.03	DR. E	0	0	0	34,500		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	336,318		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 153039

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2014 10:00 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,315,372	1,315,372			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	0		0		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,032,227	4,540	0	1,036,767	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,062,578	103,880	0	162,959	5.00
7.00 00700	OPERATION OF PLANT	909,077	508,089	0	41,627	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	7,749	16,568	0	0	8.00
9.00 00900	HOUSEKEEPING	133,271	10,439	0	10,581	9.00
10.00 01000	DIETARY	225,859	134,321	0	19,363	10.00
11.00 01100	CAFETERIA	104,125	0	0	8,642	11.00
13.00 01300	NURSING ADMINISTRATION	101,810	7,581	0	12,882	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	232,256	8,065	0	29,299	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,326,342	243,663	0	169,300	30.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	57,047	1,567	0	193	54.00
54.01 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	54.01
54.02 03951	IMAGING CENTER	45,032	0	0	0	54.02
57.00 05700	CT SCAN	1,690	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	219,973	0	0	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	291,531	2,212	0	37,850	65.00
66.00 06600	PHYSICAL THERAPY	2,147,264	118,974	0	286,995	66.00
67.00 06700	OCCUPATIONAL THERAPY	986,267	48,898	0	113,455	67.00
68.00 06800	SPEECH PATHOLOGY	135,263	7,097	0	29,921	68.00
69.00 06900	ELECTROCARDIOLOGY	4,626	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	212,456	25,071	0	6,015	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	617,311	16,130	0	40,229	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	0	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00 04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
93.02 04952	NEUROPSYCH	93,869	10,669	0	12,046	93.02
93.03 04953	SLEEP LAB	461,015	12,766	0	55,410	93.03
93.04 04954	PHYSICIANS OFFICE	102	4,609	0	0	93.04
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
97.00 09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
98.00 05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
99.00 09900	CMHC	0	0	0	0	99.00
99.10 09910	CORF	0	0	0	0	99.10
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500	KIDNEY ACQUISITION	0	0	0	0	105.00
106.00 10600	HEART ACQUISITION	0	0	0	0	106.00
107.00 10700	LIVER ACQUISITION	0	0	0	0	107.00
108.00 10800	LUNG ACQUISITION	0	0	0	0	108.00
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
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
114.00 11400	UTILIZATION REVIEW-SNF	0	0	0	0	114.00
115.00 11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	115.00
116.00 11600	HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	12,724,112	1,285,139	0	1,036,767	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	PROJECT ACCESS	0	30,233	0	0	194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	12,724,112	1,315,372	0	1,036,767	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 153039

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2014 10:00 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,329,417				5.00
7.00	00700	OPERATION OF PLANT	326,911	1,785,704			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,449	42,335	72,101		8.00
9.00	00900	HOUSEKEEPING	34,576	26,673	0	215,540	9.00
10.00	01000	DIETARY	85,054	343,210	0	43,092	850,899
11.00	01100	CAFETERIA	25,271	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	27,401	19,371	0	2,432	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	60,421	20,608	0	2,587	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	389,773	622,594	72,101	78,169	850,899
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,178	4,004	0	503	0
54.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
54.02	03951	IMAGING CENTER	10,092	0	0	0	0
57.00	05700	CT SCAN	379	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	49,295	0	0	0	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	74,309	5,652	0	710	0
66.00	06600	PHYSICAL THERAPY	572,170	303,996	0	38,168	0
67.00	06700	OCCUPATIONAL THERAPY	257,402	124,943	0	15,687	0
68.00	06800	SPEECH PATHOLOGY	38,608	18,135	0	2,277	0
69.00	06900	ELECTROCARDIOLOGY	1,037	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	54,577	64,061	0	8,043	0
73.00	07300	DRUGS CHARGED TO PATIENTS	150,967	41,216	0	5,175	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
93.02	04952	NEUROPSYCH	26,126	27,261	0	3,423	0
93.03	04953	SLEEP LAB	118,590	32,619	0	4,096	0
93.04	04954	PHYSICIANS OFFICE	1,056	11,776	0	1,479	0
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
99.00	09900	CMHC	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0
106.00	10600	HEART ACQUISITION	0	0	0	0	0
107.00	10700	LIVER ACQUISITION	0	0	0	0	0
108.00	10800	LUNG ACQUISITION	0	0	0	0	0
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
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,322,642	1,708,454	72,101	205,841	850,899
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	PROJECT ACCESS	6,775	77,250	0	9,699	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	2,329,417	1,785,704	72,101	215,540	850,899

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 153039

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2014 10:00 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	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	138,038					11.00
13.00	01300	0	171,477				13.00
16.00	01600	9,962	0	363,198			16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	37,000	102,885	108,958	4,001,684	0	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	8,574	0	85,066	0	54.00
54.01	03950	0	0	0	0	0	54.01
54.02	03951	0	0	0	55,124	0	54.02
57.00	05700	0	0	0	2,069	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	8,574	0	277,842	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	7,115	17,148	18,160	454,687	0	65.00
66.00	06600	45,538	8,574	90,800	3,612,479	0	66.00
67.00	06700	17,077	8,574	90,800	1,663,103	0	67.00
68.00	06800	2,846	8,574	18,160	260,881	0	68.00
69.00	06900	0	0	0	5,663	0	69.00
71.00	07100	1,423	0	0	371,646	0	71.00
73.00	07300	4,269	0	0	875,297	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04950	0	0	0	0	0	93.00
93.02	04952	1,423	8,574	36,320	219,711	0	93.02
93.03	04953	11,385	0	0	695,881	0	93.03
93.04	04954	0	0	0	19,022	0	93.04
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
96.00	09600	0	0	0	0	0	96.00
97.00	09700	0	0	0	0	0	97.00
98.00	05950	0	0	0	0	0	98.00
99.00	09900	0	0	0	0	0	99.00
99.10	09910	0	0	0	0	0	99.10
100.00	10000	0	0	0	0	0	100.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
105.00	10500	0	0	0	0	0	105.00
106.00	10600	0	0	0	0	0	106.00
107.00	10700	0	0	0	0	0	107.00
108.00	10800	0	0	0	0	0	108.00
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
113.00	11300	0	0	0	0	0	113.00
114.00	11400	0	0	0	0	0	114.00
115.00	11500	0	0	0	0	0	115.00
116.00	11600	0	0	0	0	0	116.00
118.00		138,038	171,477	363,198	12,600,155	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	123,957	0	194.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		138,038	171,477	363,198	12,724,112	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 153039

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2014 10:00 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	54.01
54.02	03951	IMAGING CENTER	54.02
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
60.01	06001	BLOOD LABORATORY	60.01
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	93.00
93.02	04952	NEUROPSYCH	93.02
93.03	04953	SLEEP LAB	93.03
93.04	04954	PHYSICIANS OFFICE	93.04
OTHER REIMBURSABLE COST CENTERS			
94.00	09400	HOME PROGRAM DIALYSIS	94.00
95.00	09500	AMBULANCE SERVICES	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	97.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	98.00
99.00	09900	CMHC	99.00
99.10	09910	CORF	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	100.00
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
105.00	10500	KIDNEY ACQUISITION	105.00
106.00	10600	HEART ACQUISITION	106.00
107.00	10700	LIVER ACQUISITION	107.00
108.00	10800	LUNG ACQUISITION	108.00
109.00	10900	PANCREAS ACQUISITION	109.00
110.00	11000	INTESTINAL ACQUISITION	110.00
111.00	11100	ISLET ACQUISITION	111.00
113.00	11300	INTEREST EXPENSE	113.00
114.00	11400	UTILIZATION REVIEW-SNF	114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	115.00
116.00	11600	HOSPICE	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
194.00	07950	PROJECT ACCESS	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 153039

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2014 10:00 am

Cost Center Description	CAPITAL RELATED COSTS				Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00			
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,540	0	4,540	4,540	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	103,880	0	103,880	713	5.00
7.00 00700	OPERATION OF PLANT	0	508,089	0	508,089	182	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	16,568	0	16,568	0	8.00
9.00 00900	HOUSEKEEPING	0	10,439	0	10,439	46	9.00
10.00 01000	DIETARY	0	134,321	0	134,321	85	10.00
11.00 01100	CAFETERIA	0	0	0	0	38	11.00
13.00 01300	NURSING ADMINISTRATION	0	7,581	0	7,581	56	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	8,065	0	8,065	128	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	243,663	0	243,663	741	30.00
ANCILLARY SERVICE COST CENTERS							
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	1,567	0	1,567	1	54.00
54.01 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	54.01
54.02 03951	IMAGING CENTER	0	0	0	0	0	54.02
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	2,212	0	2,212	166	65.00
66.00 06600	PHYSICAL THERAPY	0	118,974	0	118,974	1,258	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	48,898	0	48,898	497	67.00
68.00 06800	SPEECH PATHOLOGY	0	7,097	0	7,097	131	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	25,071	0	25,071	26	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	16,130	0	16,130	176	73.00
OUTPATIENT SERVICE COST CENTERS							
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
93.00 04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.02 04952	NEUROPSYCH	0	10,669	0	10,669	53	93.02
93.03 04953	SLEEP LAB	0	12,766	0	12,766	243	93.03
93.04 04954	PHYSICIANS OFFICE	0	4,609	0	4,609	0	93.04
OTHER REIMBURSABLE COST CENTERS							
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00 09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00 05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00 09900	CMHC	0	0	0	0	0	99.00
99.10 09910	CORF	0	0	0	0	0	99.10
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
105.00 10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 10600	HEART ACQUISITION	0	0	0	0	0	106.00
107.00 10700	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 10800	LUNG ACQUISITION	0	0	0	0	0	108.00
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
113.00 11300	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00 11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 11600	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,285,139	0	1,285,139	4,540	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950	PROJECT ACCESS	0	30,233	0	30,233	0	194.00
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,315,372	0	1,315,372	4,540	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 153039

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2014 10:00 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	104,593					5.00
7.00	00700	14,678	522,949				7.00
8.00	00800	245	12,398	29,211			8.00
9.00	00900	1,552	7,811	0	19,848		9.00
10.00	01000	3,819	100,510	0	3,968	242,703	10.00
11.00	01100	1,135	0	0	0	0	11.00
13.00	01300	1,230	5,673	0	224	0	13.00
16.00	01600	2,713	6,035	0	238	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	17,501	182,327	29,211	7,198	242,703	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	592	1,173	0	46	0	54.00
54.01	03950	0	0	0	0	0	54.01
54.02	03951	453	0	0	0	0	54.02
57.00	05700	17	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	2,213	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	3,336	1,655	0	65	0	65.00
66.00	06600	25,694	89,026	0	3,515	0	66.00
67.00	06700	11,557	36,590	0	1,445	0	67.00
68.00	06800	1,733	5,311	0	210	0	68.00
69.00	06900	47	0	0	0	0	69.00
71.00	07100	2,451	18,761	0	741	0	71.00
73.00	07300	6,778	12,070	0	477	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	0	0	0	0	91.00
92.00	09200						92.00
93.00	04950	0	0	0	0	0	93.00
93.02	04952	1,173	7,984	0	315	0	93.02
93.03	04953	5,325	9,553	0	377	0	93.03
93.04	04954	47	3,449	0	136	0	93.04
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
96.00	09600	0	0	0	0	0	96.00
97.00	09700	0	0	0	0	0	97.00
98.00	05950	0	0	0	0	0	98.00
99.00	09900	0	0	0	0	0	99.00
99.10	09910	0	0	0	0	0	99.10
100.00	10000	0	0	0	0	0	100.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
105.00	10500	0	0	0	0	0	105.00
106.00	10600	0	0	0	0	0	106.00
107.00	10700	0	0	0	0	0	107.00
108.00	10800	0	0	0	0	0	108.00
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
113.00	11300						113.00
114.00	11400						114.00
115.00	11500	0	0	0	0	0	115.00
116.00	11600	0	0	0	0	0	116.00
118.00		104,289	500,326	29,211	18,955	242,703	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	304	22,623	0	893	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		104,593	522,949	29,211	19,848	242,703	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 153039		Period: From 01/01/2013 To 12/31/2013		Worksheet B Part II Date/Time Prepared: 5/29/2014 10:00 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	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	1,173					11.00
13.00	01300	0	14,764				13.00
16.00	01600	85	0	17,264			16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	314	8,860	5,180	737,698	0	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	738	0	4,117	0	54.00
54.01	03950	0	0	0	0	0	54.01
54.02	03951	0	0	0	453	0	54.02
57.00	05700	0	0	0	17	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	738	0	2,951	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	60	1,476	863	9,833	0	65.00
66.00	06600	388	738	4,316	243,909	0	66.00
67.00	06700	145	738	4,316	104,186	0	67.00
68.00	06800	24	738	863	16,107	0	68.00
69.00	06900	0	0	0	47	0	69.00
71.00	07100	12	0	0	47,062	0	71.00
73.00	07300	36	0	0	35,667	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04950	0	0	0	0	0	93.00
93.02	04952	12	738	1,726	22,670	0	93.02
93.03	04953	97	0	0	28,361	0	93.03
93.04	04954	0	0	0	8,241	0	93.04
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
96.00	09600	0	0	0	0	0	96.00
97.00	09700	0	0	0	0	0	97.00
98.00	05950	0	0	0	0	0	98.00
99.00	09900	0	0	0	0	0	99.00
99.10	09910	0	0	0	0	0	99.10
100.00	10000	0	0	0	0	0	100.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
105.00	10500	0	0	0	0	0	105.00
106.00	10600	0	0	0	0	0	106.00
107.00	10700	0	0	0	0	0	107.00
108.00	10800	0	0	0	0	0	108.00
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
113.00	11300	0	0	0	0	0	113.00
114.00	11400	0	0	0	0	0	114.00
115.00	11500	0	0	0	0	0	115.00
116.00	11600	0	0	0	0	0	116.00
118.00		1,173	14,764	17,264	1,261,319	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	54,053	0	194.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		1,173	14,764	17,264	1,315,372	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 153039	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 5/29/2014 10:00 am
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	54.01
54.02	03951	IMAGING CENTER	54.02
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
60.01	06001	BLOOD LABORATORY	60.01
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	93.00
93.02	04952	NEUROPSYCH	93.02
93.03	04953	SLEEP LAB	93.03
93.04	04954	PHYSICIANS OFFICE	93.04
OTHER REIMBURSABLE COST CENTERS			
94.00	09400	HOME PROGRAM DIALYSIS	94.00
95.00	09500	AMBULANCE SERVICES	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	97.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	98.00
99.00	09900	CMHC	99.00
99.10	09910	CORF	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	100.00
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
105.00	10500	KIDNEY ACQUISITION	105.00
106.00	10600	HEART ACQUISITION	106.00
107.00	10700	LIVER ACQUISITION	107.00
108.00	10800	LUNG ACQUISITION	108.00
109.00	10900	PANCREAS ACQUISITION	109.00
110.00	11000	INTESTINAL ACQUISITION	110.00
111.00	11100	ISLET ACQUISITION	111.00
113.00	11300	INTEREST EXPENSE	113.00
114.00	11400	UTILIZATION REVIEW-SNF	114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	115.00
116.00	11600	HOSPICE	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
194.00	07950	PROJECT ACCESS	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 153039

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

Worksheet B-1
Date/Time Prepared:
5/29/2014 10:00 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	57,082				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		0			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	197	0	7,124,745		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	4,508	0	1,119,872	-2,329,417	5.00
7.00 00700	OPERATION OF PLANT	22,049	0	286,066	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	719	0	0	0	8.00
9.00 00900	HOUSEKEEPING	453	0	72,712	0	9.00
10.00 01000	DIETARY	5,829	0	133,063	0	10.00
11.00 01100	CAFETERIA	0	0	59,392	0	11.00
13.00 01300	NURSING ADMINISTRATION	329	0	88,528	0	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	350	0	201,344	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	10,574	0	1,163,447	0	30.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	68	0	1,327	0	54.00
54.01 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	54.01
54.02 03951	IMAGING CENTER	0	0	0	0	54.02
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	0	0	0	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	96	0	260,107	0	65.00
66.00 06600	PHYSICAL THERAPY	5,163	0	1,972,240	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	2,122	0	779,674	0	67.00
68.00 06800	SPEECH PATHOLOGY	308	0	205,618	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,088	0	41,333	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	700	0	276,456	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	0	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00 04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
93.02 04952	NEUROPSYCH	463	0	82,780	0	93.02
93.03 04953	SLEEP LAB	554	0	380,786	0	93.03
93.04 04954	PHYSICIANS OFFICE	200	0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
97.00 09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
98.00 05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
99.00 09900	CMHC	0	0	0	0	99.00
99.10 09910	CORF	0	0	0	0	99.10
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500	KIDNEY ACQUISITION	0	0	0	0	105.00
106.00 10600	HEART ACQUISITION	0	0	0	0	106.00
107.00 10700	LIVER ACQUISITION	0	0	0	0	107.00
108.00 10800	LUNG ACQUISITION	0	0	0	0	108.00
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
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
114.00 11400	UTILIZATION REVIEW-SNF	0	0	0	0	114.00
115.00 11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	115.00
116.00 11600	HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	55,770	0	7,124,745	-2,329,417	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	PROJECT ACCESS	1,312	0	0	0	194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 153039

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

Worksheet B-1
Date/Time Prepared:
5/29/2014 10:00 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)		
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00					4.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,315,372	0	1,036,767		2,329,417	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	23.043551	0.000000	0.145516		0.224097	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			4,540		104,593	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000637		0.010062	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 153039

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

Worksheet B-1
Date/Time Prepared:
5/29/2014 10:00 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (MANHOURS)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	30,328				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	719	43,358			8.00
9.00	00900	HOUSEKEEPING	453	0	29,156		9.00
10.00	01000	DIETARY	5,829	0	5,829	5,686	10.00
11.00	01100	CAFETERIA	0	0	0	0	97 11.00
13.00	01300	NURSING ADMINISTRATION	329	0	329	0	0 13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	350	0	350	0	7 16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	10,574	43,358	10,574	5,686	26 30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	68	0	68	0	0 54.00
54.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0 54.01
54.02	03951	IMAGING CENTER	0	0	0	0	0 54.02
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	96	0	96	0	5 65.00
66.00	06600	PHYSICAL THERAPY	5,163	0	5,163	0	32 66.00
67.00	06700	OCCUPATIONAL THERAPY	2,122	0	2,122	0	12 67.00
68.00	06800	SPEECH PATHOLOGY	308	0	308	0	2 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,088	0	1,088	0	1 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	700	0	700	0	3 73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0 93.00
93.02	04952	NEUROPSYCH	463	0	463	0	1 93.02
93.03	04953	SLEEP LAB	554	0	554	0	8 93.03
93.04	04954	PHYSICIANS OFFICE	200	0	200	0	0 93.04
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0 94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0 96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0 97.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0 98.00
99.00	09900	CMHC	0	0	0	0	0 99.00
99.10	09910	CORF	0	0	0	0	0 99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0 100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS							
105.00	10500	KIDNEY ACQUISITION	0	0	0	0	0 105.00
106.00	10600	HEART ACQUISITION	0	0	0	0	0 106.00
107.00	10700	LIVER ACQUISITION	0	0	0	0	0 107.00
108.00	10800	LUNG ACQUISITION	0	0	0	0	0 108.00
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
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0 115.00
116.00	11600	HOSPICE	0	0	0	0	0 116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,016	43,358	27,844	5,686	97 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
191.00	19100	RESEARCH	0	0	0	0	0 191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0 193.00
194.00	07950	PROJECT ACCESS	1,312	0	1,312	0	0 194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,785,704	72,101	215,540	850,899	138,038 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	58.879715	1.662923	7.392646	149.648083	1,423.072165 203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 153039

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

Worksheet B-1

Date/Time Prepared:
5/29/2014 10:00 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (MANHOURS)	
		7.00	8.00	9.00	10.00	11.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	522,949	29,211	19,848	242,703	1,173	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	17.243109	0.673716	0.680752	42.684312	12.092784	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 153039

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

Worksheet B-1
Date/Time Prepared:
5/29/2014 10:00 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		13.00	16.00	
GENERAL SERVICE COST CENTERS				
1.00	00100			1.00
2.00	00200			2.00
4.00	00400			4.00
5.00	00500			5.00
7.00	00700			7.00
8.00	00800			8.00
9.00	00900			9.00
10.00	01000			10.00
11.00	01100			11.00
13.00	01300	100		13.00
16.00	01600	0	1,000	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	60	300	30.00
ANCILLARY SERVICE COST CENTERS				
54.00	05400	5	0	54.00
54.01	03950	0	0	54.01
54.02	03951	0	0	54.02
57.00	05700	0	0	57.00
58.00	05800	0	0	58.00
59.00	05900	0	0	59.00
60.00	06000	5	0	60.00
60.01	06001	0	0	60.01
65.00	06500	10	50	65.00
66.00	06600	5	250	66.00
67.00	06700	5	250	67.00
68.00	06800	5	50	68.00
69.00	06900	0	0	69.00
71.00	07100	0	0	71.00
73.00	07300	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	0	0	91.00
92.00	09200	0	0	92.00
93.00	04950	0	0	93.00
93.02	04952	5	100	93.02
93.03	04953	0	0	93.03
93.04	04954	0	0	93.04
OTHER REIMBURSABLE COST CENTERS				
94.00	09400	0	0	94.00
95.00	09500	0	0	95.00
96.00	09600	0	0	96.00
97.00	09700	0	0	97.00
98.00	05950	0	0	98.00
99.00	09900	0	0	99.00
99.10	09910	0	0	99.10
100.00	10000	0	0	100.00
101.00	10100	0	0	101.00
SPECIAL PURPOSE COST CENTERS				
105.00	10500	0	0	105.00
106.00	10600	0	0	106.00
107.00	10700	0	0	107.00
108.00	10800	0	0	108.00
109.00	10900	0	0	109.00
110.00	11000	0	0	110.00
111.00	11100	0	0	111.00
113.00	11300	0	0	113.00
114.00	11400	0	0	114.00
115.00	11500	0	0	115.00
116.00	11600	0	0	116.00
118.00		100	1,000	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	0	0	190.00
191.00	19100	0	0	191.00
192.00	19200	0	0	192.00
193.00	19300	0	0	193.00
194.00	07950	0	0	194.00
200.00				200.00
201.00				201.00
202.00		171,477	363,198	202.00
203.00		1,714.770000	363.198000	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 153039

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

Worksheet B-1

Date/Time Prepared:
5/29/2014 10:00 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		13.00	16.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	14,764	17,264	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	147.640000	17.264000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 153039	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/29/2014 10:00 am	
			Title XVIII	Hospital	PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		4,001,684	0	4,001,684	30.00
ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADIOLOGY-DIAGNOSTIC		85,066	0	85,066	54.00
54.01	03950 OTHER ANCILLARY SERVICE COST CENTERS		0	0	0	54.01
54.02	03951 IMAGING CENTER		55,124	0	55,124	54.02
57.00	05700 CT SCAN		2,069	0	2,069	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	06000 LABORATORY		277,842	0	277,842	60.00
60.01	06001 BLOOD LABORATORY		0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	454,687	0	454,687	65.00
66.00	06600 PHYSICAL THERAPY	0	3,612,479	0	3,612,479	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,663,103	0	1,663,103	67.00
68.00	06800 SPEECH PATHOLOGY	0	260,881	0	260,881	68.00
69.00	06900 ELECTROCARDIOLOGY		5,663	0	5,663	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		371,646	0	371,646	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS		875,297	0	875,297	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY		0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	92.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER		0	0	0	93.00
93.02	04952 NEUROPSYCH		219,711	0	219,711	93.02
93.03	04953 SLEEP LAB		695,881	0	695,881	93.03
93.04	04954 PHYSICIANS OFFICE		19,022	0	19,022	93.04
OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS		0	0	0	94.00
95.00	09500 AMBULANCE SERVICES		0	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED		0	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD		0	0	0	97.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS		0	0	0	98.00
99.00	09900 CMHC		0	0	0	99.00
99.10	09910 CORF		0	0	0	99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM		0	0	0	100.00
101.00	10100 HOME HEALTH AGENCY		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00	10500 KIDNEY ACQUISITION		0	0	0	105.00
106.00	10600 HEART ACQUISITION		0	0	0	106.00
107.00	10700 LIVER ACQUISITION		0	0	0	107.00
108.00	10800 LUNG ACQUISITION		0	0	0	108.00
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
113.00	11300 INTEREST EXPENSE		0	0	0	113.00
114.00	11400 UTILIZATION REVIEW-SNF		0	0	0	114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)		0	0	0	115.00
116.00	11600 HOSPICE		0	0	0	116.00
200.00	Subtotal (see instructions)		12,600,155	0	12,600,155	200.00
201.00	Less Observation Beds		0	0	0	201.00
202.00	Total (see instructions)		12,600,155	0	12,600,155	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153039

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2014 10:00 am

		Title XVIII			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,595,743		5,595,743		30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	271,030	0	271,030	0.313862	54.00
54.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	54.01
54.02	03951	IMAGING CENTER	136,446	0	136,446	0.403999	54.02
57.00	05700	CT SCAN	166,256	0	166,256	0.012445	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	1,388,469	0	1,388,469	0.200107	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	628,491	17,571	646,062	0.703782	65.00
66.00	06600	PHYSICAL THERAPY	2,019,407	9,211,017	11,230,424	0.321669	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,131,450	1,064,544	3,195,994	0.520371	67.00
68.00	06800	SPEECH PATHOLOGY	219,882	138,698	358,580	0.727539	68.00
69.00	06900	ELECTROCARDIOLOGY	104,224	0	104,224	0.054335	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	52,936	8,956	61,892	6.004750	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,121,447	0	1,121,447	0.780507	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	93.00
93.02	04952	NEUROPSYCH	236,643	137,170	373,813	0.587756	93.02
93.03	04953	SLEEP LAB	0	3,960,621	3,960,621	0.175700	93.03
93.04	04954	PHYSICIANS OFFICE	0	0	0	0.000000	93.04
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	97.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
99.00	09900	CMHC	0	0	0		99.00
99.10	09910	CORF	0	0	0		99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS							
105.00	10500	KIDNEY ACQUISITION	0	0	0		105.00
106.00	10600	HEART ACQUISITION	0	0	0		106.00
107.00	10700	LIVER ACQUISITION	0	0	0		107.00
108.00	10800	LUNG ACQUISITION	0	0	0		108.00
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
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0		115.00
116.00	11600	HOSPICE	0	0	0		116.00
200.00		Subtotal (see instructions)	14,072,424	14,538,577	28,611,001		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	14,072,424	14,538,577	28,611,001		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 153039	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/29/2014 10:00 am
		Title XVIII	Hospital	PPS
Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS				
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.313862		54.00
54.01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000		54.01
54.02	03951 IMAGING CENTER	0.403999		54.02
57.00	05700 CT SCAN	0.012445		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	0.200107		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	0.703782		65.00
66.00	06600 PHYSICAL THERAPY	0.321669		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.520371		67.00
68.00	06800 SPEECH PATHOLOGY	0.727539		68.00
69.00	06900 ELECTROCARDIOLOGY	0.054335		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6.004750		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.780507		73.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
93.02	04952 NEUROPSYCH	0.587756		93.02
93.03	04953 SLEEP LAB	0.175700		93.03
93.04	04954 PHYSICIANS OFFICE	0.000000		93.04
OTHER REIMBURSABLE COST CENTERS				
94.00	09400 HOME PROGRAM DIALYSIS	0.000000		94.00
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000		97.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
99.00	09900 CMHC			99.00
99.10	09910 CORF			99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM			100.00
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
105.00	10500 KIDNEY ACQUISITION			105.00
106.00	10600 HEART ACQUISITION			106.00
107.00	10700 LIVER ACQUISITION			107.00
108.00	10800 LUNG ACQUISITION			108.00
109.00	10900 PANCREAS ACQUISITION			109.00
110.00	11000 INTESTINAL ACQUISITION			110.00
111.00	11100 ISLET ACQUISITION			111.00
113.00	11300 INTEREST EXPENSE			113.00
114.00	11400 UTILIZATION REVIEW-SNF			114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)			115.00
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153039

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2014 10:00 am

		Title XIX		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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	4,001,684		4,001,684	0	4,001,684	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	85,066		85,066	0	85,066	54.00
54.01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	54.01
54.02	03951 IMAGING CENTER	55,124		55,124	0	55,124	54.02
57.00	05700 CT SCAN	2,069		2,069	0	2,069	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000 LABORATORY	277,842		277,842	0	277,842	60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	454,687	0	454,687	0	454,687	65.00
66.00	06600 PHYSICAL THERAPY	3,612,479	0	3,612,479	0	3,612,479	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,663,103	0	1,663,103	0	1,663,103	67.00
68.00	06800 SPEECH PATHOLOGY	260,881	0	260,881	0	260,881	68.00
69.00	06900 ELECTROCARDIOLOGY	5,663		5,663	0	5,663	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	371,646		371,646	0	371,646	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	875,297		875,297	0	875,297	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0		0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0	0	92.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
93.02	04952 NEUROPSYCH	219,711		219,711	0	219,711	93.02
93.03	04953 SLEEP LAB	695,881		695,881	0	695,881	93.03
93.04	04954 PHYSICIANS OFFICE	19,022		19,022	0	19,022	93.04
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0		0	0	0	94.00
95.00	09500 AMBULANCE SERVICES	0		0	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
99.00	09900 CMHC	0		0	0	0	99.00
99.10	09910 CORF	0		0	0	0	99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0		0	0	0	100.00
101.00	10100 HOME HEALTH AGENCY	0		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
105.00	10500 KIDNEY ACQUISITION	0		0	0	0	105.00
106.00	10600 HEART ACQUISITION	0		0	0	0	106.00
107.00	10700 LIVER ACQUISITION	0		0	0	0	107.00
108.00	10800 LUNG ACQUISITION	0		0	0	0	108.00
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
113.00	11300 INTEREST EXPENSE	0		0	0	0	113.00
114.00	11400 UTILIZATION REVIEW-SNF	0		0	0	0	114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)	0		0	0	0	115.00
116.00	11600 HOSPICE	0		0	0	0	116.00
200.00	Subtotal (see instructions)	12,600,155	0	12,600,155	0	12,600,155	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	12,600,155	0	12,600,155	0	12,600,155	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153039

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2014 10:00 am

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,595,743		5,595,743		30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	271,030	0	271,030	0.313862	54.00
54.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	54.01
54.02	03951	IMAGING CENTER	136,446	0	136,446	0.403999	54.02
57.00	05700	CT SCAN	166,256	0	166,256	0.012445	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	1,388,469	0	1,388,469	0.200107	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	628,491	17,571	646,062	0.703782	65.00
66.00	06600	PHYSICAL THERAPY	2,019,407	9,211,017	11,230,424	0.321669	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,131,450	1,064,544	3,195,994	0.520371	67.00
68.00	06800	SPEECH PATHOLOGY	219,882	138,698	358,580	0.727539	68.00
69.00	06900	ELECTROCARDIOLOGY	104,224	0	104,224	0.054335	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	52,936	8,956	61,892	6.004750	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,121,447	0	1,121,447	0.780507	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	93.00
93.02	04952	NEUROPSYCH	236,643	137,170	373,813	0.587756	93.02
93.03	04953	SLEEP LAB	0	3,960,621	3,960,621	0.175700	93.03
93.04	04954	PHYSICIANS OFFICE	0	0	0	0.000000	93.04
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	97.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
99.00	09900	CMHC	0	0	0		99.00
99.10	09910	CORF	0	0	0		99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS							
105.00	10500	KIDNEY ACQUISITION	0	0	0		105.00
106.00	10600	HEART ACQUISITION	0	0	0		106.00
107.00	10700	LIVER ACQUISITION	0	0	0		107.00
108.00	10800	LUNG ACQUISITION	0	0	0		108.00
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
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0		115.00
116.00	11600	HOSPICE	0	0	0		116.00
200.00		Subtotal (see instructions)	14,072,424	14,538,577	28,611,001		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	14,072,424	14,538,577	28,611,001		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 153039	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/29/2014 10:00 am
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS				
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000		54.01
54.02	03951 IMAGING CENTER	0.000000		54.02
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
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
93.02	04952 NEUROPSYCH	0.000000		93.02
93.03	04953 SLEEP LAB	0.000000		93.03
93.04	04954 PHYSICIANS OFFICE	0.000000		93.04
OTHER REIMBURSABLE COST CENTERS				
94.00	09400 HOME PROGRAM DIALYSIS	0.000000		94.00
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000		97.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
99.00	09900 CMHC			99.00
99.10	09910 CORF			99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM			100.00
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
105.00	10500 KIDNEY ACQUISITION			105.00
106.00	10600 HEART ACQUISITION			106.00
107.00	10700 LIVER ACQUISITION			107.00
108.00	10800 LUNG ACQUISITION			108.00
109.00	10900 PANCREAS ACQUISITION			109.00
110.00	11000 INTESTINAL ACQUISITION			110.00
111.00	11100 ISLET ACQUISITION			111.00
113.00	11300 INTEREST EXPENSE			113.00
114.00	11400 UTILIZATION REVIEW-SNF			114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)			115.00
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 153039		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part I Date/Time Prepared: 5/29/2014 10:00 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	737,698	0	737,698	5,686	129.74	30.00
200.00	Total (Lines 30-199)	737,698		737,698	5,686		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	4,654	603,810				
200.00	Total (Lines 30-199)	4,654	603,810				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 153039	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/29/2014 10:00 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	
Title XVIII Hospital PPS								
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,117	271,030	0.015190	253,660	3,853	54.00
54.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	54.01
54.02	03951	IMAGING CENTER	453	136,446	0.003320	92,180	306	54.02
57.00	05700	CT SCAN	17	166,256	0.000102	127,079	13	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	2,951	1,388,469	0.002125	1,166,542	2,479	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	9,833	646,062	0.015220	470,478	7,161	65.00
66.00	06600	PHYSICAL THERAPY	243,909	11,230,424	0.021719	1,662,628	36,111	66.00
67.00	06700	OCCUPATIONAL THERAPY	104,186	3,195,994	0.032599	1,734,680	56,549	67.00
68.00	06800	SPEECH PATHOLOGY	16,107	358,580	0.044919	177,841	7,988	68.00
69.00	06900	ELECTROCARDIOLOGY	47	104,224	0.000451	63,212	29	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	47,062	61,892	0.760389	42,233	32,114	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,667	1,121,447	0.031804	871,141	27,706	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
93.02	04952	NEUROPSYCH	22,670	373,813	0.060645	0	0	93.02
93.03	04953	SLEEP LAB	28,361	3,960,621	0.007161	0	0	93.03
93.04	04954	PHYSICIANS OFFICE	8,241	0	0.000000	0	0	93.04
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00		Total (lines 50-199)	523,621	23,015,258		6,661,674	174,309	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 153039		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part III Date/Time Prepared: 5/29/2014 10:00 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,686	0.00	4,654	0	0	30.00
200.00		Total (lines 30-199)	5,686		4,654	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 153039	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/29/2014 10:00 am
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Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS									
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
54.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	0	54.01
54.02	03951	IMAGING CENTER	0	0	0	0	0	0	54.02
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
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
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	0	93.00
93.02	04952	NEUROPSYCH	0	0	0	0	0	0	93.02
93.03	04953	SLEEP LAB	0	0	0	0	0	0	93.03
93.04	04954	PHYSICIANS OFFICE	0	0	0	0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	0	97.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	0	98.00
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: 153039	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/29/2014 10:00 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	271,030	0.000000	0.000000	253,660	54.00
54.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	54.01
54.02	03951	IMAGING CENTER	0	136,446	0.000000	0.000000	92,180	54.02
57.00	05700	CT SCAN	0	166,256	0.000000	0.000000	127,079	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	1,388,469	0.000000	0.000000	1,166,542	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	646,062	0.000000	0.000000	470,478	65.00
66.00	06600	PHYSICAL THERAPY	0	11,230,424	0.000000	0.000000	1,662,628	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,195,994	0.000000	0.000000	1,734,680	67.00
68.00	06800	SPEECH PATHOLOGY	0	358,580	0.000000	0.000000	177,841	68.00
69.00	06900	ELECTROCARDIOLOGY	0	104,224	0.000000	0.000000	63,212	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	61,892	0.000000	0.000000	42,233	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,121,447	0.000000	0.000000	871,141	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
93.02	04952	NEUROPSYCH	0	373,813	0.000000	0.000000	0	93.02
93.03	04953	SLEEP LAB	0	3,960,621	0.000000	0.000000	0	93.03
93.04	04954	PHYSICIANS OFFICE	0	0	0.000000	0.000000	0	93.04
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	0.000000	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0.000000	0	97.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00
200.00		Total (lines 50-199)	0	23,015,258			6,661,674	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 153039	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/29/2014 10:00 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
Title XVIII Hospital PPS						
ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	54.01
54.02	03951	IMAGING CENTER	0	0	0	54.02
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	16,701	0	65.00
66.00	06600	PHYSICAL THERAPY	0	7,492	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,291	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	93.00
93.02	04952	NEUROPSYCH	0	0	0	93.02
93.03	04953	SLEEP LAB	0	1,338,687	0	93.03
93.04	04954	PHYSICIANS OFFICE	0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	97.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	98.00
200.00		Total (lines 50-199)	0	1,364,171	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 153039	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/29/2014 10:00 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.313862	0	0	0	0	54.00
54.01	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	54.01
54.02	03951	IMAGING CENTER	0.403999	0	0	0	0	54.02
57.00	05700	CT SCAN	0.012445	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.200107	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.703782	16,701	0	0	11,754	65.00
66.00	06600	PHYSICAL THERAPY	0.321669	7,492	0	0	2,410	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.520371	1,291	0	0	672	67.00
68.00	06800	SPEECH PATHOLOGY	0.727539	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.054335	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6.004750	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.780507	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
93.02	04952	NEUROPSYCH	0.587756	0	0	0	0	93.02
93.03	04953	SLEEP LAB	0.175700	1,338,687	0	0	235,207	93.03
93.04	04954	PHYSICIANS OFFICE	0.000000	0	0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00
95.00	09500	AMBULANCE SERVICES	0.000000	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		1,364,171	0	0	250,043	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		1,364,171	0	0	250,043	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 153039	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/29/2014 10:00 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	54.01
54.02 03951	IMAGING CENTER	0	0	54.02
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
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
91.00 09100	EMERGENCY	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00 04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
93.02 04952	NEUROPSYCH	0	0	93.02
93.03 04953	SLEEP LAB	0	0	93.03
93.04 04954	PHYSICIANS OFFICE	0	0	93.04
OTHER REIMBURSABLE COST CENTERS				
94.00 09400	HOME PROGRAM DIALYSIS	0	0	94.00
95.00 09500	AMBULANCE SERVICES	0	0	95.00
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
97.00 09700	DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
98.00 05950	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
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: 153039	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/29/2014 10:00 am
Cost Center Description		PPS		
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,686	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,686	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)		5,686	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		4,654	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,001,684	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,001,684	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,001,684	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		703.78	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,275,392	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)		3,275,392	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 153039	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/29/2014 10:00 am
Title XVIII			Hospital		PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,186,828 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,462,220 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					603,810 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					174,309 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					778,119 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					5,684,101 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 153039		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/29/2014 10:00 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	737,698	4,001,684	0.184347	0	0	90.00
91.00	Nursing School cost	0	4,001,684	0.000000	0	0	91.00
92.00	Allied health cost	0	4,001,684	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,001,684	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 153039	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/29/2014 10:00 am
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,686	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,686	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)		5,686	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		97	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,001,684	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,001,684	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,001,684	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		703.78	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		68,267	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)		68,267	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 153039	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/29/2014 10:00 am
Cost Center Description			Title XIX	Hospital	Cost
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
Cost Center Description					
					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				82,996 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				151,263 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				0 54.00
55.00	Target amount per discharge				0.00 55.00
56.00	Target amount (line 54 x line 55)				0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0 57.00
58.00	Bonus payment (see instructions)				0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0 61.00
62.00	Relief payment (see instructions)				0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)				70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				71.00
72.00	Program routine service cost (line 9 x line 71)				72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				76.00
77.00	Program capital-related costs (line 9 x line 76)				77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				80.00
81.00	Inpatient routine service cost per diem limitation				81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				82.00
83.00	Reasonable inpatient routine service costs (see instructions)				83.00
84.00	Program inpatient ancillary services (see instructions)				84.00
85.00	Utilization review - physician compensation (see instructions)				85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)				0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 153039		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/29/2014 10:00 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: 153039	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/29/2014 10:00 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	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		4,650,166		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.313862	253,660	79,614	54.00
54.01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	54.01
54.02	03951 IMAGING CENTER	0.403999	92,180	37,241	54.02
57.00	05700 CT SCAN	0.012445	127,079	1,581	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.200107	1,166,542	233,433	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.703782	470,478	331,114	65.00
66.00	06600 PHYSICAL THERAPY	0.321669	1,662,628	534,816	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.520371	1,734,680	902,677	67.00
68.00	06800 SPEECH PATHOLOGY	0.727539	177,841	129,386	68.00
69.00	06900 ELECTROCARDIOLOGY	0.054335	63,212	3,435	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6.004750	42,233	253,599	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.780507	871,141	679,932	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
93.02	04952 NEUROPSYCH	0.587756	0	0	93.02
93.03	04953 SLEEP LAB	0.175700	0	0	93.03
93.04	04954 PHYSICIANS OFFICE	0.000000	0	0	93.04
OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
95.00	09500 AMBULANCE SERVICES				95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50-94 and 96-98)		6,661,674	3,186,828	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)		6,661,674		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 153039	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/29/2014 10:00 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	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		115,925		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.313862	2,333	732	54.00
54.01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	54.01
54.02	03951 IMAGING CENTER	0.403999	0	0	54.02
57.00	05700 CT SCAN	0.012445	2,986	37	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.200107	24,207	4,844	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.703782	16,360	11,514	65.00
66.00	06600 PHYSICAL THERAPY	0.321669	44,826	14,419	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.520371	45,836	23,852	67.00
68.00	06800 SPEECH PATHOLOGY	0.727539	6,093	4,433	68.00
69.00	06900 ELECTROCARDIOLOGY	0.054335	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6.004750	468	2,810	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.780507	21,151	16,509	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
93.02	04952 NEUROPSYCH	0.587756	6,544	3,846	93.02
93.03	04953 SLEEP LAB	0.175700	0	0	93.03
93.04	04954 PHYSICIANS OFFICE	0.000000	0	0	93.04
OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
95.00	09500 AMBULANCE SERVICES				95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50-94 and 96-98)		170,804	82,996	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)		170,804		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 153039	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/29/2014 10:00 am
		Title XVII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		250,043	2.00
3.00	PPS payments		483,726	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a 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)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		483,726	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		161,342	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)		322,384	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)		322,384	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		322,384	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		322,384	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		322,384	40.00
40.01	Sequestration adjustment (see instructions)		4,868	40.01
41.00	Interim payments		319,941	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-2,425	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 153039		Period: From 01/01/2013 To 12/31/2013		Worksheet E-1 Part I Date/Time Prepared: 5/29/2014 10:00 am	
		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		5,703,371		319,941	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)		5,703,371		319,941	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		35,421		2,425	6.02	
7.00	Total Medicare program liability (see instructions)		5,667,950		317,516	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 153039	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part III Date/Time Prepared: 5/29/2014 10:00 am
		Title XVIII	Hospital	PPS
		Prior to 10/01	On/After 10/01	
		1.00	1.01	
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)	5,843,859	0	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0167		2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	89,995	0	3.00
4.00	Outlier Payments	39,001		4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00		5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00		5.01
6.00	New Teaching program adjustment. (see instructions)	0.00		6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program". (see inst.)	0.00		7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program". (see inst.)	0.00		8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00		9.00
10.00	Average Daily Census (see instructions)	15.578082		10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	0	12.00
13.00	Total PPS Payment (see instructions)	5,972,855		13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0		14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			15.00
16.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0		16.00
17.00	Subtotal (see instructions)	5,972,855		17.00
18.00	Primary payer payments	24,034		18.00
19.00	Subtotal (line 17 less line 18).	5,948,821		19.00
20.00	Deductibles	183,324		20.00
21.00	Subtotal (line 19 minus line 20)	5,765,497		21.00
22.00	Coinsurance	10,649		22.00
23.00	Subtotal (line 21 minus line 22)	5,754,848		23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0		24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0		25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		26.00
27.00	Subtotal (sum of lines 23 and 25)	5,754,848		27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0		28.00
29.00	Other pass through costs (see instructions)	0		29.00
30.00	Outlier payments reconciliation	0		30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		31.00
31.99	Recovery of Accelerated Depreciation	0		31.99
32.00	Total amount payable to the provider (see instructions)	5,754,848		32.00
32.01	Sequestration adjustment (see instructions)	86,898		32.01
33.00	Interim payments	5,703,371		33.00
34.00	Tentative settlement (for contractor use only)	0		34.00
35.00	Balance due provider/program line 32 minus lines 32.01, 33 and 34	-35,421		35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0		36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4	39,001		50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0		51.00
52.00	The rate used to calculate the Time Value of Money	0.00		52.00
53.00	Time Value of Money (see instructions)	0		53.00

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

Provider CCN: 153039

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

Worksheet G

Date/Time Prepared:
5/29/2014 10:00 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	1,713,170	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,963,251	0	0	0	4.00
5.00	Other receivable	23,958	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,296,110	0	0	0	6.00
7.00	Inventory	217,672	0	0	0	7.00
8.00	Prepaid expenses	76,845	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	3,698,786	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	90,000	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	9,363	0	0	0	15.00
16.00	Accumulated depreciation	0	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	25,449	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	725,742	0	0	0	23.00
24.00	Accumulated depreciation	-287,728	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	562,826	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	-325,093	0	0	0	33.00
34.00	Other assets	490,967	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	165,874	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	4,427,486	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	718,520	0	0	0	37.00
38.00	Salaries, wages, and fees payable	567,781	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	16,126	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,302,427	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	1,302,427	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	3,125,059	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)	3,125,059	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	4,427,486	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 153039

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

Worksheet G-1

Date/Time Prepared:
5/29/2014 10:00 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		3,020,184		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		104,875				2.00
3.00	Total (sum of line 1 and line 2)		3,125,059		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		3,125,059		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		3,125,059		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: 153039

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/29/2014 10:00 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	5,658,079		5,658,079	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,658,079		5,658,079	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,658,079		5,658,079	17.00
18.00	Ancillary services	8,526,912		8,526,912	18.00
19.00	Outpatient services	0	14,893,813	14,893,813	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	0	0	0	24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	25.00
26.00	HOSPICE	0	0	0	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)	14,184,991	14,893,813	29,078,804	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		12,776,715		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		12,776,715		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 153039

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

Worksheet G-3

Date/Time Prepared:
5/29/2014 10:00 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	29,078,804	1.00
2.00	Less contractual allowances and discounts on patients' accounts	16,543,739	2.00
3.00	Net patient revenues (line 1 minus line 2)	12,535,065	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	12,776,715	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-241,650	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	1,073	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	18,505	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	HRSC MISCELLANEOUS REVENUE	281,823	24.00
24.01	MISCELLANEOUS OTHER REVENUE	3,747	24.01
24.02	DONATIONS AND GRANTS	37,976	24.02
24.03	RECLASS REVENUE ERROR	1,549	24.03
24.04	NON-OPERATING INCOME	1,852	24.04
25.00	Total other income (sum of lines 6-24)	346,525	25.00
26.00	Total (line 5 plus line 25)	104,875	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	104,875	29.00