

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

FORM APPROVED  
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151318	Period: From 01/01/2013 To 12/31/2013	Worksheet 5 Parts I-III Date/Time Prepared: 5/30/2014 2:22 pm
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**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 5/30/2014	Time: 2:22 pm
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

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

**CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)**

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by DUKES MEMORIAL HOSPITAL ( 151318 ) for the cost reporting period beginning 01/01/2013 and ending 12/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

**Encryption Information**

ECR: Date: 5/30/2014 Time: 2:22 pm  
DPRkT4gju4k0VJOjXRnDbAQVovYrB0  
VzfwD0wMANZNa6DXfNGte.OWFVUjsA  
vZ0y0158UI0XKFP1  
PI: Date: 5/30/2014 Time: 2:22 pm  
HHnje8nV0V0Supi0Zymjobj1vatHD0  
IunFt0ImXrq.bvr9mtkIF1oVJ4EpcI  
WgpI0fLLx:0swUDT

(signed) W. Close  
Officer or Administrator of Provider(s)  
Title CEO  
Date 6/2/14

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00	Hospital	0	701,709	51,868	203,584	0 1.00
2.00	Subprovider - IPF	0	0	0	0	0 2.00
3.00	Subprovider - IRF	0	0	0	0	0 3.00
5.00	Swing bed - SNF	0	13,753	0	0	0 5.00
6.00	Swing bed - NF	0	0	0	0	0 6.00
200.00	Total	0	715,462	51,868	203,584	0 200.00

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

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**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/30/2014 Time: 2:22 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN
		10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

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**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 DUKES MEMORIAL HOSPITAL ( 151318 ) 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.

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

Title \_\_\_\_\_

Date \_\_\_\_\_

Cost Center Description	Title V 1 00	Title XVIII		HIT 4 00	Title XIX 5 00	
		Part A 2 00	Part B 3 00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	701,709	51,868	203,584	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	13,753	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	715,462	51,868	203,584	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151318	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/30/2014 1:53 pm
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1.00 Hospital and Hospital Health Care Complex Address:		2.00		3.00		4.00	
1.00	Street: 275 WEST 12TH STREET	PO Box:	Zip Code: 46970		County: MIAMI		1.00
2.00	City: PERU	State: IN					2.00
		Component Name	CCN Number	CBSA number	Provider Type	Date Certified	Payment System (P, T, O, or N)
							V XVIII XIX
		1.00	2.00	3.00	4.00	5.00	6.00 7.00 8.00

3.00 Hospital and Hospital-Based Component Identification:								
3.00	Hospital	DUKES MEMORIAL HOSPITAL	151318	99915	1	07/01/1966	N O P	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	DUKES MEMORIAL HOSPITAL SB	152318	99915		12/01/2003	N O N	7.00
8.00	Swing Beds - NF							8.00
9.00	Hospital-Based SNF							9.00
10.00	Hospital-Based NF							10.00
11.00	Hospital-Based OLTC							11.00
12.00	Hospital-Based HHA							12.00
13.00	Separately Certified ASC							13.00
14.00	Hospital-Based Hospice							14.00
15.00	Hospital-Based Health Clinic - RHC							15.00
16.00	Hospital-Based Health Clinic - FQHC							16.00
17.00	Hospital-Based (CMHC) I							17.00
18.00	Renal Dialysis							18.00
19.00	Other							19.00

		From	To	
20.00	Cost Reporting Period (mm/dd/yyyy)	1.00	2.00	
		01/01/2013	12/31/2013	
21.00	Type of Control (see instructions)	4		21.00

22.00 Inpatient PPS Information							
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N					22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						22.01
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	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 days	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	25.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151318	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/30/2014 1:53 pm			
		Beginning 1.00	Ending 2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00		
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00		
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00		
		Y/N 1.00	Y/N 2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)				39.00		
		V 1.00	X/III 2.00	X/N 3.00			
<b>Prospective Payment System (PPS)-Capital</b>							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00		
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00		
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00		
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00		
<b>Teaching Hospitals</b>							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.	N			58.00		
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.	N			59.00		
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00		
		Y/N 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 5.00	
61.00	Did your hospital receive FTE slots under ACA section §503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery (see instructions)		0.00	0.00			61.06
			Program Name 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.				0.00	0.00	61.10

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20	
						1.00	
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>							
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00	
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
				1.00	2.00	3.00	
<b>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.</b>							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
				1.00	2.00	3.00	
<b>Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010</b>							
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151318

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

Worksheet S-2  
Part I  
Date/Time Prepared:  
5/30/2014 1:53 pm

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

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			V 1.00	XI 2.00		
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N			108.00
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	N	109.00
				1.00	2.00	3.00
<b>Miscellaneous Cost Reporting Information</b>						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1			118.00
			Premiums 1.00	Losses 2.00	Insurance 3.00	
118.01	List amounts of malpractice premiums and paid losses:	154,086	29,390			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.		Y			121.00
<b>Transplant Center Information</b>						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			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
<b>All Providers</b>						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y		449008	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151318	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/30/2014 1:53 pm
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	1 00	2 00	3 00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.				
141.00	Name: CHS/COMMUNITY HEALTH SYSTEMS, INC.	Contractor's Name: WPS	Contractor's Number: 52280	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

144.00	Are provider based physicians' costs included in worksheet A?	1 00	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.	2 00	Y	145.00

146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	1 00	N	146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	2 00	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	3 00	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	4 00	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	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

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

	Name	County	State	Zip Code	CBSA	FTE/Campus		
	0	1 00	2 00	3 00	4 00	5 00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00

<b>Health Information Technology (HIT) Incentive in the American Recovery and Reinvestment Act</b>							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					255,899	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.75	169.00

		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)	10/01/2012	09/30/2013	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151318	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/30/2014 1:53 pm	
			Y/N	Date	
			1 00	2 00	
<b>General Instruction:</b> Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
<b>COMPLETED BY ALL HOSPITALS</b>					
<b>Provider Organization and Operation</b>					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1 00	2 00	3 00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		Y		3.00
			Y/N	Type	Date
			1 00	2 00	3 00
<b>Financial Data and Reports</b>					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		N		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N		5.00
			Y/N	Legal Oper.	
			1 00	2 00	
<b>Approved Educational Activities</b>					
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		
<b>Bad Debts</b>					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
<b>Bed Complement</b>					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
			Y/N		
			1 00		
<b>PS&amp;R Data</b>					
		Description	Y/N	Date	Y/N
		0	1 00	2 00	3 00
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	04/22/2014	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

	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	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			Y	35.00
				Y/N	Date
				1 00	2 00
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1 00	2 00
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RYAN		NELSON	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS, INC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-7541		ED_ROSE@CHS.NET	43.00

		Part B	
		Date	
		4 00	
<b>PS&amp;R Data</b>			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	04/22/2014	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	
<b>Cost Report Preparer Contact Information</b>			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	Title v
	Line Number					
	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	21	7,665	72,288.00	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)		21	7,665	72,288.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	13,080.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,125	85,368.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

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)	1,670	123	3,012			1.00
2.00 HMO and other (see instructions)	234	368				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	493	0	546			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)	2,163	123	3,558			7.00
8.00 INTENSIVE CARE UNIT	265	62	545			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		57	449			13.00
14.00 Total (see instructions)	2,428	242	4,552	0.00	204.39	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	204.39	27.00
28.00 Observation Bed Days		0	769			28.00
29.00 Ambulance Trips	1,139					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

Component	Discharges					Total All Patients	
	Full Time Equivalents	Title V	Title XVIII	Title XIX			
	Nonpaid workers						
	11 00	12 00	13 00	14 00	15 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	530	221	1,098	1.00
2.00 HMO and other (see instructions)				67			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	530	221	1,098	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151318	Period: From 01/01/2013 To 12/31/2013	Worksheet S-10 Date/Time Prepared: 5/30/2014 1:53 pm
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			1.00		
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.239829	1.00	
<b>Medicaid (see instructions for each line)</b>					
2.00	Net revenue from Medicaid		2,729,664	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		2,593,574	5.00	
6.00	Medicaid charges		20,874,834	6.00	
7.00	Medicaid cost (line 1 times line 6)		5,006,391	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00	
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
<b>Other state or local government indigent care program (see instructions for each line)</b>					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		727,833	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		2,939,189	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		704,903	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
<b>Uncompensated care (see instructions for each line)</b>					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00	
			1.00		
			Uninsured patients	Insured patients	
			1.00	2.00	
			Total (col 1 + col 2)	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	364,833	0	364,833	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	87,498	0	87,498	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	87,498	0	87,498	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		5,144,757	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		784,774	27.00	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		4,359,983	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,045,650	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,133,148	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,133,148	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151318

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

Worksheet A  
Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description		Salaries	Other	Total (col 1 + col 2)	Reclassification Adjustments (See A-6)	Reclassified Trial Balance (col 3 + col 4)	
		1 00	2 00	3 00	4 00	5 00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		676,491	676,491	404,175	1,080,666	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		1,654,662	1,654,662	372,190	2,026,852	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	88,829	61,909	150,738	1,254,655	1,405,393	4.00
5.01	00540 ADMITTING	0	0	0	5,523,969	5,523,969	5.01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL	2,121,754	10,567,047	12,688,801	-7,193,216	5,495,585	5.02
7.00	00700 OPERATION OF PLANT	229,357	1,081,785	1,311,142	2,696	1,313,838	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	95,360	95,360	0	95,360	8.00
9.00	00900 HOUSEKEEPING	234,952	67,289	302,241	0	302,241	9.00
10.00	01000 DIETARY	190,314	165,558	355,872	-187,626	168,246	10.00
11.00	01100 CAFETERIA	0	0	0	186,571	186,571	11.00
13.00	01300 NURSING ADMINISTRATION	275,469	213,460	488,929	-272,260	216,669	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	74,603	323,656	398,259	-196,434	201,825	14.00
15.00	01500 PHARMACY	362,447	754,747	1,117,194	-691,451	425,743	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	140,445	240,003	380,448	84,547	464,995	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	1,527,008	682,761	2,209,769	-68,650	2,141,119	30.00
31.00	03100 INTENSIVE CARE UNIT	351,450	44,649	396,099	-1,206	394,893	31.00
43.00	04300 NURSERY	0	0	0	56,285	56,285	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	469,161	1,206,376	1,675,537	-562,014	1,113,523	50.00
51.00	05100 RECOVERY ROOM	245,773	38,616	284,389	-1,120	283,269	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	496,666	218,331	714,997	526,784	1,241,781	54.00
54.01	05401 ULTRASOUND	106,155	15,540	121,695	-121,695	0	54.01
56.00	05600 RADIOISOTOPE	68,186	105,398	173,584	-173,584	0	56.00
57.00	05700 CT SCAN	53,788	118,365	172,153	-172,153	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	43,367	98,542	141,909	-141,909	0	58.00
60.00	06000 LABORATORY	588,390	835,543	1,423,933	-41,171	1,382,762	60.00
65.00	06500 RESPIRATORY THERAPY	335,065	52,732	387,797	-1,462	386,335	65.00
66.00	06600 PHYSICAL THERAPY	2,109	621,735	623,844	-1,180	622,664	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	228,006	228,006	0	228,006	67.00
68.00	06800 SPEECH PATHOLOGY	0	83,337	83,337	0	83,337	68.00
69.00	06900 ELECTROCARDIOLOGY	124,441	23,770	148,211	-1,055	147,156	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	230,909	230,909	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	448,764	448,764	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	624,571	624,571	73.00
76.00	03020 SLEEP LAB	112,342	15,951	128,293	-1,911	126,382	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	251,360	49,118	300,478	-4,158	296,320	90.00
91.00	09100 EMERGENCY	2,792,340	645,363	3,437,703	-3,454	3,434,249	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	208,488	125,018	333,506	-3,958	329,548	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	11,494,259	21,111,118	32,605,377	-125,551	32,479,826	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	478	12,198	12,676	-12,676	0	192.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951 MARKETING	0	0	0	138,227	138,227	194.01
194.02	07952 SENIOR CIRCLE	0	-741	-741	0	-741	194.02
194.03	07953 FREE MEALS	0	0	0	0	0	194.03
200.00	TOTAL (SUM OF LINES 118-199)	11,494,737	21,122,575	32,617,312	0	32,617,312	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151318

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

Worksheet A

Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	353,255	1,433,921	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	-170,648	1,856,204	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-1,993	1,403,400	4.00
5.01	00540 ADMITTING	-4,236,136	1,287,833	5.01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL	-216,900	5,278,685	5.02
7.00	00700 OPERATION OF PLANT	2,370	1,316,208	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	-15,249	80,111	8.00
9.00	00900 HOUSEKEEPING	0	302,241	9.00
10.00	01000 DIETARY	0	168,246	10.00
11.00	01100 CAFETERIA	-63,430	123,141	11.00
13.00	01300 NURSING ADMINISTRATION	-7,464	209,205	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	201,825	14.00
15.00	01500 PHARMACY	0	425,743	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-11,582	453,413	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS	-384,000	1,757,119	30.00
31.00	03100 INTENSIVE CARE UNIT	0	394,893	31.00
43.00	04300 NURSERY	0	56,285	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	-300,999	812,524	50.00
51.00	05100 RECOVERY ROOM	0	283,269	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	-16,160	1,225,621	54.00
54.01	05401 ULTRASOUND	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000 LABORATORY	0	1,382,762	60.00
65.00	06500 RESPIRATORY THERAPY	0	386,335	65.00
66.00	06600 PHYSICAL THERAPY	0	622,664	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	228,006	67.00
68.00	06800 SPEECH PATHOLOGY	0	83,337	68.00
69.00	06900 ELECTROCARDIOLOGY	-3,144	144,012	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	230,909	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	448,764	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	624,571	73.00
76.00	03020 SLEEP LAB	0	126,382	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0	296,320	90.00
91.00	09100 EMERGENCY	0	3,434,249	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0	329,548	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00	SUBTOTALS (SUM OF LINES 1-117)	-5,072,080	27,407,746	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951 MARKETING	-8,483	129,744	194.01
194.02	07952 SENIOR CIRCLE	0	-741	194.02
194.03	07953 FREE MEALS	0	0	194.03
200.00	TOTAL (SUM OF LINES 118-199)	-5,080,563	27,536,749	200.00

		Increases			
Cost Center		Line #	Salary	other	
2 00		3 00	4 00	5 00	
<b>A - EMPLOYEE BENEFITS</b>					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,255,775	1.00
	TOTALS		0	1,255,775	
<b>B - OXYGEN</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	31,098	1.00
	TOTALS		0	31,098	
<b>C - LEASE AND RENT</b>					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	345,369	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
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
	TOTALS		0	345,369	
<b>D - OTHER CAPITAL COSTS</b>					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	61,479	1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	342,696	2.00
3.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	26,821	3.00
	TOTALS		0	430,996	
<b>E - MARKETING</b>					
1.00	MARKETING	194.01	50,812	87,415	1.00
	TOTALS		50,812	87,415	
<b>F - CNO</b>					
1.00	NURSING ADMINISTRATION	13.00	159,009	0	1.00
	TOTALS		159,009	0	
<b>G - CHARGABLE MEDICAL SUPPLIES</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	199,811	1.00
2.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	448,764	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	648,575	
<b>H - DRUGS AND IVS</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	624,571	1.00
	TOTALS		0	624,571	
<b>I - NURSERY</b>					
1.00	NURSERY	43.00	47,585	8,700	1.00
	TOTALS		47,585	8,700	
<b>J - QUALITY AND CASE MANAGEMENT</b>					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	146,469	194,950	1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	81,592	5,545	2.00
	TOTALS		228,061	200,495	
<b>K - FRAGMENTED A&amp;G</b>					
1.00	ADMITTING	5.01	614,875	4,909,094	1.00
	TOTALS		614,875	4,909,094	
<b>L - RADIOLOGY</b>					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	271,496	337,387	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
	TOTALS		271,496	337,387	

		Increases				
	Cost Center	Line #	Salary	Other		
	2 00	3 00	3 00	5 00		
1.00	<b>M - DIETARY</b>					
	CAFETERIA	11.00	100,072	86,499		1.00
	TOTALS		100,072	86,499		
1.00	<b>N - POB UTILITIES</b>					
	OPERATION OF PLANT	7.00	478	12,139		1.00
	TOTALS		478	12,139		
500.00	Grand Total: Increases		1,472,388	8,978,113		500.00

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst A-7 Ref	
	6 00	7 00	8 00	9 00	10 00	
<b>A - EMPLOYEE BENEFITS</b>						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	1,255,775	0	1.00
	TOTALS		0	1,255,775		
<b>B - OXYGEN</b>						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	31,098	0	1.00
	TOTALS		0	31,098		
<b>C - LEASE AND RENT</b>						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,120	10	1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	26,659	0	2.00
3.00	OPERATION OF PLANT	7.00	0	9,921	0	3.00
4.00	DIETARY	10.00	0	1,055	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	2,713	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	10,462	0	6.00
7.00	PHARMACY	15.00	0	66,880	0	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,590	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	12,365	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	1,206	0	10.00
11.00	OPERATING ROOM	50.00	0	68,483	0	11.00
12.00	RECOVERY ROOM	51.00	0	1,120	0	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	82,099	0	13.00
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	458	0	14.00
15.00	LABORATORY	60.00	0	41,171	0	15.00
16.00	RESPIRATORY THERAPY	65.00	0	1,292	0	16.00
17.00	PHYSICAL THERAPY	66.00	0	1,180	0	17.00
18.00	ELECTROCARDIOLOGY	69.00	0	1,055	0	18.00
19.00	SLEEP LAB	76.00	0	1,911	0	19.00
20.00	CLINIC	90.00	0	4,158	0	20.00
21.00	EMERGENCY	91.00	0	3,454	0	21.00
22.00	AMBULANCE SERVICES	95.00	0	3,958	0	22.00
23.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	59	0	23.00
	TOTALS		0	345,369		
<b>D - OTHER CAPITAL COSTS</b>						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	430,996	12	1.00
2.00		0.00	0	0	13	2.00
3.00		0.00	0	0	12	3.00
	TOTALS		0	430,996		
<b>E - MARKETING</b>						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	50,812	87,415	0	1.00
	TOTALS		50,812	87,415		
<b>F - CNO</b>						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	159,009	0	0	1.00
	TOTALS		159,009	0		
<b>G - CHARGABLE MEDICAL SUPPLIES</b>						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	154,874	0	1.00
2.00	OPERATING ROOM	50.00	0	493,531	0	2.00
3.00	RESPIRATORY THERAPY	65.00	0	170	0	3.00
	TOTALS		0	648,575		
<b>H - DRUGS AND IVS</b>						
1.00	PHARMACY	15.00	0	624,571	0	1.00
	TOTALS		0	624,571		
<b>I - NURSERY</b>						
1.00	ADULTS & PEDIATRICS	30.00	47,585	8,700	0	1.00
	TOTALS		47,585	8,700		
<b>J - QUALITY AND CASE MANAGEMENT</b>						
1.00	NURSING ADMINISTRATION	13.00	228,061	200,495	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		228,061	200,495		
<b>K - FRAGMENTED A&amp;G</b>						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	614,875	4,909,094	0	1.00
	TOTALS		614,875	4,909,094		
<b>L - RADIOLOGY</b>						
1.00	ULTRASOUND	54.01	106,155	15,540	0	1.00
2.00	RADIOISOTOPE	56.00	68,186	105,398	0	2.00
3.00	CT SCAN	57.00	53,788	118,365	0	3.00
4.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	43,367	98,084	0	4.00
	TOTALS		271,496	337,387		

		Decreases				
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref	
6 00		7 00	8 00	9 00	10 00	
<b>M - DIETARY</b>						
1.00	DIETARY	10.00	100,072	86,499	0	1.00
	TOTALS		100,072	86,499		
<b>N - POB UTILITIES</b>						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	478	12,139	0	1.00
	TOTALS		478	12,139		
500.00	Grand Total: Decreases		1,472,388	8,978,113		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151318

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/30/2014 1:53 pm

	Beginning Balances	ACQUISITIONS			Disposals and Retirements	
		Purchases	Donation	Total		
	1 00	2 00	3 00	4 00	5 00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	193,225	0	0	0	1.00
2.00	Land Improvements	974,444	0	0	0	2.00
3.00	Buildings and Fixtures	19,863,486	40,820	0	40,820	3.00
4.00	Building Improvements	5,700,250	61,167	0	61,167	4.00
5.00	Fixed Equipment	2,001,824	105,055	0	105,055	5.00
6.00	Movable Equipment	17,939,161	716,609	0	716,609	6.00
7.00	HIT designated Assets	2,038,462	255,899	0	255,899	7.00
8.00	Subtotal (sum of lines 1-7)	48,710,852	1,179,550	0	1,179,550	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	48,710,852	1,179,550	0	1,179,550	10.00
	Ending Balance		Fully Depreciated Assets			
	6 00		7 00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	193,225	0			1.00
2.00	Land Improvements	936,429	0			2.00
3.00	Buildings and Fixtures	19,904,306	0			3.00
4.00	Building Improvements	5,689,616	0			4.00
5.00	Fixed Equipment	2,103,059	0			5.00
6.00	Movable Equipment	17,088,698	0			6.00
7.00	HIT designated Assets	2,294,361	0			7.00
8.00	Subtotal (sum of lines 1-7)	48,209,694	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	48,209,694	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151318

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	676,491	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,654,662	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,331,153	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				
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	676,491		1.00		
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,654,662		2.00		
3.00	Total (sum of lines 1-2)	0	2,331,153		3.00		

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151318

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see Instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	676,491	0	676,491	0.290196	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,654,662	0	1,654,662	0.709804	0	2.00
3.00	Total (sum of lines 1-2)	2,331,153	0	2,331,153	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		
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,016,180	-4,788	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,389,365	345,612	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,405,545	340,824	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		
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	17,179	61,479	343,871	0	1,433,921	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	94,406	26,821	0	0	1,856,204	2.00
3.00	Total (sum of lines 1-2)	111,585	88,300	343,871	0	3,290,125	3.00

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on worksheet A To/From which the Amount is to be Adjusted					
				Cost Center	Line #	Wkst	A-7 Ref.		
				1 00	2 00	3 00	4 00	5 00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	NEW CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00	Investment income - other (chapter 2)			0		0.00		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	-722,825					0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-171		RADIOLOGY-DIAGNOSTIC	54.00		0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	17,669					0	12.00
13.00	Laundry and linen service			0		0.00		0	13.00
14.00	Cafeteria-employees and guests	B	-63,430		CAFETERIA	11.00		0	14.00
15.00	Rental of quarters to employee and others			0		0.00		0	15.00
16.00	Sale of medical and surgical supplies to other than patients			0		0.00		0	16.00
17.00	Sale of drugs to other than patients			0		0.00		0	17.00
18.00	Sale of medical records and abstracts	B	-11,582		MEDICAL RECORDS & LIBRARY	16.00		0	18.00
19.00	Nursing school (tuition, fees, books, etc.)			0		0.00		0	19.00
20.00	Vending machines	B	-2,467		OTHER ADMINISTRATIVE AND GENERAL	5.02		0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00		0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00		0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0		RESPIRATORY THERAPY	65.00			23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0		PHYSICAL THERAPY	66.00			24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00			25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	A	339,689		NEW CAP REL COSTS-BLDG & FIXT	1.00		9	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	A	101,308		NEW CAP REL COSTS-MVBLE EQUIP	2.00		9	27.00
28.00	Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00			28.00
29.00	Physicians' assistant			0		0.00		0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0		OCCUPATIONAL THERAPY	67.00			30.00
30.99	Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00			30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0		SPEECH PATHOLOGY	68.00			31.00

Provider CCN: 151318

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

Worksheet A-8  
Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted		Line #	Wkst A-7 Ref
				Cost Center	Line #		
		1 00	2 00	3 00	4 00	5 00	
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-356,617	NEW CAP REL COSTS-MVBLE EQUIP	2.00		9 32.00
33.00	SILVER RECOVERY	B	-15,989	RADIOLOGY-DIAGNOSTIC	54.00		0 33.00
35.00	TRAINING REVENUE	B	-7,464	NURSING ADMINISTRATION	13.00		0 35.00
36.00	FITNESS REVENUE	B	-495	OTHER ADMINISTRATIVE AND GENERAL	5.02		0 36.00
37.00	OTHER MISC REVENUE - HOSPITAL	B	-12,781	OTHER ADMINISTRATIVE AND GENERAL	5.02		0 37.00
38.00	HOSPITAL BAD DEBT	A	-4,184,701	ADMITTING	5.01		0 38.00
40.00	PATIENT PHONES WAGE COST	A	-11,344	OTHER ADMINISTRATIVE AND GENERAL	5.02		0 40.00
41.00	PATIENT PHONES BENEFITS COST	A	-2,018	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 41.00
42.00	PATIENT PHONES EXPENSE	A	-5,075	OTHER ADMINISTRATIVE AND GENERAL	5.02		0 42.00
43.00	PATIENT PHONES DEPRECIATION COST	A	-7,419	NEW CAP REL COSTS-MVBLE EQUIP	2.00		9 43.00
44.00	PATIENT TV SERVICE COST	A	-8,701	OTHER ADMINISTRATIVE AND GENERAL	5.02		0 44.00
44.01	PATIENT TV DEPRECIATION	A	-2,569	NEW CAP REL COSTS-MVBLE EQUIP	2.00		9 44.01
45.00	MARKETING EXPENSE	A	-70,588	OTHER ADMINISTRATIVE AND GENERAL	5.02		0 45.00
45.01	PENALTIES	A	-909	OTHER ADMINISTRATIVE AND GENERAL	5.02		0 45.01
45.02	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-1,981	OTHER ADMINISTRATIVE AND GENERAL	5.02		0 45.02
45.03	CHARITABLE CONTRIBUTIONS	A	-19,309	OTHER ADMINISTRATIVE AND GENERAL	5.02		0 45.03
45.04	BOARD AND STAFF RELATIONS	A	-676	OTHER ADMINISTRATIVE AND GENERAL	5.02		0 45.04
45.05	PHYSICIAN RECRUITING	A	-28,949	OTHER ADMINISTRATIVE AND GENERAL	5.02		0 45.05
45.06	POB UTILITIES	A	2,370	OPERATION OF PLANT	7.00		0 45.06
45.07	POB COPIER LEASE	A	54	NEW CAP REL COSTS-MVBLE EQUIP	2.00		10 45.07
45.08	POB PROPERTY TAX	A	1,175	NEW CAP REL COSTS-BLDG & FIXT	1.00		13 45.08
45.09	NON-ALLOWABLE INTEREST	A	-5	OTHER ADMINISTRATIVE AND GENERAL	5.02		0 45.09
45.10	RENTAL INCOME	B	-4,788	NEW CAP REL COSTS-BLDG & FIXT	1.00		10 45.10
45.11	EMPLOYED PHYSICIAN MARKETING	A	25	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 45.11
45.12			0		0.00		0 45.12
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-5,080,563				50.00

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

Provider CCN: 151318

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

Worksheet A-8-1

Date/Time Prepared: 5/30/2014 1:53 pm

Line No	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks A, column 5	
1 00	2 00	3 00	4 00	5 00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED</b>					
<b>HOME OFFICE COSTS:</b>					
1.00	1.00	NEW CAP REL COSTS-BLDG & FIX	PASI CAPITAL COSTS - BLDG &	5,753	0
2.00	2.00	NEW CAP REL COSTS-MVBLE EQUI	PASI CAPITAL COSTS - MOVEABL	2,878	0
3.00	5.01	ADMITTING	PASI OPERATING COSTS	103,859	0
4.00	1.00	NEW CAP REL COSTS-BLDG & FIX	NEW CAPITAL - BUILDING & FIX	11,426	0
4.01	2.00	NEW CAP REL COSTS-MVBLE EQUI	NEW CAPITAL - MOVABLE EQUIPM	91,528	0
4.02	5.02	OTHER ADMINISTRATIVE AND GEN	NON-CAPITAL HOME OFFICE COST	695,595	0
4.03	5.02	OTHER ADMINISTRATIVE AND GEN	MALPRACTICE	183,476	307,792
4.05	2.00	NEW CAP REL COSTS-MVBLE EQUI	CIG LEASED EQUIPMENT	57,220	57,031
4.06	8.00	LAUNDRY & LINEN SERVICE	HOSPITAL LAUNDRY SERVICE	107,638	122,887
4.07	5.02	OTHER ADMINISTRATIVE AND GEN	MANAGEMENT FEES	0	253,176
4.08	5.02	OTHER ADMINISTRATIVE AND GEN	401K FEES	0	989
4.09	5.02	OTHER ADMINISTRATIVE AND GEN	AUDIT FEES	0	19,273
4.10	5.02	OTHER ADMINISTRATIVE AND GEN	MIS FEES	0	186,558
4.11	5.02	OTHER ADMINISTRATIVE AND GEN	MANAGED CARE	0	10,636
4.12	5.02	OTHER ADMINISTRATIVE AND GEN	CASE MANAGEMENT	0	51,953
4.13	5.02	OTHER ADMINISTRATIVE AND GEN	PURCHASE & ANCILLARY	0	3,809
4.14	5.02	OTHER ADMINISTRATIVE AND GEN	EMERGENCY ROOM	0	28,374
4.15	5.02	OTHER ADMINISTRATIVE AND GEN	PBS FEES	0	19,648
4.16	5.02	OTHER ADMINISTRATIVE AND GEN	COMPLIANCE/HIM/CCA FEES	0	15,801
4.17	194.01	MARKETING	SENIOR CIRCLE	0	8,483
4.18	5.01	ADMITTING	PASI COLLECTION FEES	0	123,214
4.19	5.01	ADMITTING	PASI EBOS	0	1,882
4.20	5.01	ADMITTING	PASI LIEN UNIT COLLECTION FE	0	30,198
5.00	0		0	1,259,373	1,241,704

\* 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>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>				

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

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

6.00	B		0.00	COMMUNITY HEALTH SYTEMS	100.00	6.00
7.00	G		0.00	PASI	0.00	7.00
8.00	G		0.00	HOSPITAL LAUNDRY SERVICE	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:	RELATED CORP				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: 151318

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

worksheet A-8-1

Date/Time Prepared:  
5/30/2014 1:53 pm

	Net Adjustments (col 4 minus col 5)*	wkst. A-7 Ref		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	5,753	11		1.00
2.00	2,878	11		2.00
3.00	103,859	0		3.00
4.00	11,426	11		4.00
4.01	91,528	11		4.01
4.02	695,595	0		4.02
4.03	-124,316	0		4.03
4.05	189	10		4.05
4.06	-15,249	0		4.06
4.07	-253,176	0		4.07
4.08	-989	0		4.08
4.09	-19,273	0		4.09
4.10	-186,558	0		4.10
4.11	-10,636	0		4.11
4.12	-51,953	0		4.12
4.13	-3,809	0		4.13
4.14	-28,374	0		4.14
4.15	-19,648	0		4.15
4.16	-15,801	0		4.16
4.17	-8,483	0		4.17
4.18	-123,214	0		4.18
4.19	-1,882	0		4.19
4.20	-30,198	0		4.20
5.00	17,669			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	HOSPITAL MANAGEMENT	6.00
7.00	DEBT COLLECTION	7.00
8.00	LAUNDRY SERVICE	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.

1.00	5.02	OTHER ADMINISTRATIVE AND GENERAL	39,504	34,682	4,822	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	384,000	384,000	0	0	0	2.00
3.00	50.00	OPERATING ROOM	300,999	300,999	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	3,144	3,144	0	0	0	4.00
5.00	91.00	EMERGENCY	1,747,798	0	1,747,798	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			2,475,445	722,825	1,752,620	0	0	200.00
1.00	5.02	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
1.00	5.02	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	34,682		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	384,000		2.00
3.00	50.00	OPERATING ROOM	0	0	0	300,999		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	3,144		4.00
5.00	91.00	EMERGENCY	0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	722,825		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151318	Period: From 01/01/2013 To 12/31/2013	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/30/2014 1:53 pm
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	Physical Therapy	Cost	
		1.00	

PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52 1.00
2.00	Line 1 multiplied by 15 hours per week		780 2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		0 3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0 4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0 5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0 6.00
7.00	Standard travel expense rate	0.00	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

	Supervisors 1.00	Therapists 2.00	Assistants 3.00	Aides 4.00	Trainees 5.00	
9.00	Total hours worked	0.00	4,946.25	5,146.04	2,238.53	0.00 9.00
10.00	AHSEA (see instructions)	0.00	73.69	55.26	16.58	0.00 10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.85	36.85	27.63		
12.00	Number of travel hours (provider site)	0	0	0		12.00
12.01	Number of travel hours (offsite)	0	0	0		12.01
13.00	Number of miles driven (provider site)	0	0	0		13.00
13.01	Number of miles driven (offsite)	0	0	0		13.01

Part II - SALARY EQUIVALENCY COMPUTATION			
14.00	Supervisors (column 1, line 9 times column 1, line 10)		0 14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		364,489 15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)		284,370 16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		648,859 17.00
18.00	Aides (column 4, line 9 times column 4, line 10)		37,115 18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)		0 19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		685,974 20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.			
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		0.00 21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		0 22.00
23.00	Total salary equivalency (see instructions)		685,974 23.00

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE			
Standard Travel Allowance			
24.00	Therapists (line 3 times column 2, line 11)		0 24.00
25.00	Assistants (line 4 times column 3, line 11)		0 25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		0 26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		0 27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		0 28.00
Optional Travel Allowance and Optional Travel Expense			
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		0 29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		0 30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		0 31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0 32.00
33.00	Standard travel allowance and standard travel expense (line 28)		0 33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0 34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0 35.00

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE			
Standard Travel Expense			
36.00	Therapists (line 5 times column 2, line 11)		0 36.00
37.00	Assistants (line 6 times column 3, line 11)		0 37.00
38.00	Subtotal (sum of lines 36 and 37)		0 38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		0 39.00
Optional Travel Allowance and Optional Travel Expense			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0 40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0 41.00
42.00	Subtotal (sum of lines 40 and 41)		0 42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0 43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.			
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0 44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0 45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151318	Period: From 01/01/2013 To 12/31/2013	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/30/2014 1:53 pm
		Physical Therapy	Cost

					1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)				0	46.00
		Therapists	Assistants	Aides	Trainees	Total
		1.00	2.00	3.00	4.00	5.00

<b>PART V - OVERTIME COMPUTATION</b>							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	9.95	0.00	2.52	0.00	12.47	47.00
48.00	Overtime rate (see instructions)	110.54	82.89	24.87	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	1,099.87	0.00	62.67	0.00		49.00
<b>CALCULATION OF LIMIT</b>							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	79.79	0.00	20.21	0.00	100.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	1,659.63	0.00	420.37	0.00	2,080.00	51.00
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
52.00	Adjusted hourly salary equivalency amount (see instructions)	73.69	55.26	16.58	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	122,298	0	6,970	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	1,100	0	63	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	733	0	42	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	367	0	21	0	388	56.00
						1.00	

<b>Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT</b>							
57.00	Salary equivalency amount (from line 23)					685,974	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					388	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					686,362	63.00
64.00	Total cost of outside supplier services (from your records)					608,384	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
<b>LINE 33 CALCULATION</b>							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					0	100.02
<b>LINE 34 CALCULATION</b>							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					0	101.02
<b>LINE 35 CALCULATION</b>							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151318	Period: From 01/01/2013 To 12/31/2013	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/30/2014 1:53 pm		
			Occupational Therapy	Cost		
				1.00		
<b>PART I - GENERAL INFORMATION</b>						
1.00	Total number of weeks worked (excluding aides) (see instructions)			52	1.00	
2.00	Line 1 multiplied by 15 hours per week			780	2.00	
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)			0	3.00	
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)			0	4.00	
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)			0	5.00	
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)			0	6.00	
7.00	Standard travel expense rate			0.00	7.00	
8.00	Optional travel expense rate per mile			0.00	8.00	
		Supervisors 1.00	Therapists 2.00	Assistants 3.00	Aides 4.00	Trainees 5.00
9.00	Total hours worked	0.00	3,400.78	34.89	0.00	0.00
10.00	AHSEA (see instructions)	0.00	69.85	52.39	15.72	0.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.93	34.93	26.20		
12.00	Number of travel hours (provider site)	0	0	0		
12.01	Number of travel hours (offsite)	0	0	0		
13.00	Number of miles driven (provider site)	0	0	0		
13.01	Number of miles driven (offsite)	0	0	0		
				1.00		
<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>						
14.00	Supervisors (column 1, line 9 times column 1, line 10)			0	14.00	
15.00	Therapists (column 2, line 9 times column 2, line 10)			237,544	15.00	
16.00	Assistants (column 3, line 9 times column 3, line 10)			1,828	16.00	
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)			239,372	17.00	
18.00	Aides (column 4, line 9 times column 4, line 10)			0	18.00	
19.00	Trainees (column 5, line 9 times column 5, line 10)			0	19.00	
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)			239,372	20.00	
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)			0.00	21.00	
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)			0	22.00	
23.00	Total salary equivalency (see instructions)			239,372	23.00	
<b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE</b>						
<b>Standard Travel Allowance</b>						
24.00	Therapists (line 3 times column 2, line 11)			0	24.00	
25.00	Assistants (line 4 times column 3, line 11)			0	25.00	
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)			0	26.00	
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)			0	27.00	
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)			0	28.00	
<b>Optional Travel Allowance and Optional Travel Expense</b>						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)			0	29.00	
30.00	Assistants (column 3, line 10 times column 3, line 12)			0	30.00	
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)			0	31.00	
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)			0	32.00	
33.00	Standard travel allowance and standard travel expense (line 28)			0	33.00	
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)			0	34.00	
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)			0	35.00	
<b>PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE</b>						
<b>Standard Travel Expense</b>						
36.00	Therapists (line 5 times column 2, line 11)			0	36.00	
37.00	Assistants (line 6 times column 3, line 11)			0	37.00	
38.00	Subtotal (sum of lines 36 and 37)			0	38.00	
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)			0	39.00	
<b>Optional Travel Allowance and Optional Travel Expense</b>						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)			0	40.00	
41.00	Assistants (column 3, line 12.01 times column 3, line 10)			0	41.00	
42.00	Subtotal (sum of lines 40 and 41)			0	42.00	
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)			0	43.00	
<b>Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.</b>						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)			0	44.00	

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151318	Period: From 01/01/2013 To 12/31/2013	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/30/2014 1:53 pm Cost
			Occupational Therapy

						1 00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)						0 45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)						0 46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1 00	2 00	3 00	4 00	5 00	

**PART V - OVERTIME COMPUTATION**

47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00

**CALCULATION OF LIMIT**

50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00

**DETERMINATION OF OVERTIME ALLOWANCE**

52.00	Adjusted hourly salary equivalency amount (see instructions)	69.85	52.39	15.72	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

1 00

**Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT**

57.00	Salary equivalency amount (from line 23)					239,372	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					239,372	63.00
64.00	Total cost of outside supplier services (from your records)					227,698	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00

**LINE 33 CALCULATION**

100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						0 100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0 100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						0 100.02

**LINE 34 CALCULATION**

101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0 101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0 101.01
101.02	Line 34 = sum of lines 27 and 31						0 101.02

**LINE 35 CALCULATION**

102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0 102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0 102.01
102.02	Line 35 = sum of lines 31 and 32						0 102.02



REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151318	Period: From 01/01/2013 To 12/31/2013	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/30/2014 1:53 pm
		Speech Pathology	Cost

46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					1 00	0	46.00
		Therapists	Assistants	Aides	Trainees	Total		
		1 00	2 00	3 00	4 00	5 00		

<b>PART V - OVERTIME COMPUTATION</b>								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00		49.00
<b>CALCULATION OF LIMIT</b>								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00		51.00
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>								
52.00	Adjusted hourly salary equivalency amount (see instructions)	67.14	50.35	15.11	0.00			52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0			53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0			54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0			55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0			56.00

						1 00		
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<b>Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT</b>								
57.00	Salary equivalency amount (from line 23)					108,152		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35)					0		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0		59.00
60.00	Overtime allowance (from column 5, line 56)					0		60.00
61.00	Equipment cost (see instructions)					0		61.00
62.00	Supplies (see instructions)					0		62.00
63.00	Total allowance (sum of lines 57-62)					108,152		63.00
64.00	Total cost of outside supplier services (from your records)					82,887		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0		65.00

<b>LINE 33 CALCULATION</b>								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					0		100.02

<b>LINE 34 CALCULATION</b>								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0		101.01
101.02	Line 34 = sum of lines 27 and 31					0		101.02

<b>LINE 35 CALCULATION</b>								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0		102.01
102.02	Line 35 = sum of lines 31 and 32					0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151318

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkct A col 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1 00	2 00	4 00	5 01	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	1,433,921	1,433,921			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	1,856,204		1,856,204		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,403,400	10,119	13,153	1,426,672	4.00
5.01 00540	ADMITTING	1,287,833	15,396	20,012	76,910	5.01
5.02 00560	OTHER ADMINISTRATIVE AND GENERAL	5,278,685	73,003	94,890	180,559	5.02
7.00 00700	OPERATION OF PLANT	1,316,208	424,330	551,545	28,748	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	80,111	16,659	21,654	0	8.00
9.00 00900	HOUSEKEEPING	302,241	13,792	17,927	29,388	9.00
10.00 01000	DIETARY	168,246	34,821	45,261	11,288	10.00
11.00 01100	CAFETERIA	123,141	22,365	29,070	12,517	11.00
13.00 01300	NURSING ADMINISTRATION	209,205	6,504	8,454	25,819	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	201,825	34,132	44,364	9,331	14.00
15.00 01500	PHARMACY	425,743	15,933	20,710	45,336	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	453,413	28,796	37,430	27,773	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	1,757,119	239,023	310,684	185,049	30.00
31.00 03100	INTENSIVE CARE UNIT	394,893	27,700	36,005	43,960	31.00
43.00 04300	NURSERY	56,285	5,481	7,124	5,952	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	812,524	109,814	142,736	58,684	50.00
51.00 05100	RECOVERY ROOM	283,269	7,905	10,275	30,742	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,225,621	77,235	100,391	96,083	54.00
54.01 05401	ULTRASOUND	0	0	0	0	54.01
56.00 05600	RADIOISOTOPE	0	0	0	0	56.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00 06000	LABORATORY	1,382,762	30,880	40,138	73,597	60.00
65.00 06500	RESPIRATORY THERAPY	386,335	13,255	17,229	41,911	65.00
66.00 06600	PHYSICAL THERAPY	622,664	18,191	23,645	264	66.00
67.00 06700	OCCUPATIONAL THERAPY	228,006	5,952	7,737	0	67.00
68.00 06800	SPEECH PATHOLOGY	83,337	240	311	0	68.00
69.00 06900	ELECTROCARDIOLOGY	144,012	8,994	11,690	15,565	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	230,909	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	448,764	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	624,571	0	0	0	73.00
76.00 03020	SLEEP LAB	126,382	12,841	16,691	14,052	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	296,320	8,348	10,851	31,441	90.00
91.00 09100	EMERGENCY	3,434,249	53,194	69,141	349,269	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	329,548	21,421	27,843	26,078	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	27,407,746	1,336,324	1,736,961	1,420,316	1,400,151
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,858	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	91,739	119,243	0	192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01 07951	MARKETING	129,744	0	0	6,356	194.01
194.02 07952	SENIOR CIRCLE	-741	0	0	0	194.02
194.03 07953	FREE MEALS	0	0	0	0	194.03
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	TOTAL (sum lines 118-201)	27,536,749	1,433,921	1,856,204	1,426,672	1,400,151

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151318

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

Worksheet #  
Part I  
Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description		Suhtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5A 01	5 02	7 00	8 00	9 00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 ADMITTING						5.01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL	5,627,137	5,627,137				5.02
7.00	00700 OPERATION OF PLANT	2,320,831	596,047	2,916,878			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	118,424	30,414	53,336	202,174		8.00
9.00	00900 HOUSEKEEPING	363,348	93,317	44,156	0	500,821	9.00
10.00	01000 DIETARY	259,616	66,676	111,483	0	19,803	10.00
11.00	01100 CAFETERIA	187,093	48,050	71,603	0	12,719	11.00
13.00	01300 NURSING ADMINISTRATION	249,982	64,202	20,823	0	3,699	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	289,652	74,390	109,275	0	19,411	14.00
15.00	01500 PHARMACY	507,722	130,396	51,012	0	9,062	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	547,412	140,589	92,194	0	16,377	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	2,569,049	659,796	765,253	80,260	135,935	30.00
31.00	03100 INTENSIVE CARE UNIT	514,253	132,073	88,685	4,921	15,753	31.00
43.00	04300 NURSERY	79,897	20,520	17,546	0	3,117	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	1,303,114	334,672	351,578	33,548	62,452	50.00
51.00	05100 RECOVERY ROOM	364,453	93,601	25,309	0	4,496	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,755,092	450,752	247,276	22,844	43,925	54.00
54.01	05401 ULTRASOUND	0	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000 LABORATORY	1,721,736	442,185	98,864	331	17,562	60.00
65.00	06500 RESPIRATORY THERAPY	476,971	122,498	42,437	0	7,538	65.00
66.00	06600 PHYSICAL THERAPY	716,298	183,963	58,240	0	10,345	66.00
67.00	06700 OCCUPATIONAL THERAPY	257,879	66,230	19,057	0	3,385	67.00
68.00	06800 SPEECH PATHOLOGY	86,733	22,275	767	0	136	68.00
69.00	06900 ELECTROCARDIOLOGY	226,222	58,099	28,795	0	5,115	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	285,958	73,441	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	480,709	123,458	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	785,493	201,734	0	0	0	73.00
76.00	03020 SLEEP LAB	180,223	46,286	41,112	5,063	7,303	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	353,440	90,772	26,726	0	4,748	90.00
91.00	09100 EMERGENCY	4,095,418	1,051,817	170,304	55,207	30,252	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	460,395	118,241	68,582	0	12,183	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	27,184,550	5,536,494	2,604,413	202,174	445,316	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,858	1,504	18,755	0	3,332	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	210,982	54,185	293,710	0	52,173	192.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951 MARKETING	136,100	34,954	0	0	0	194.01
194.02	07952 SENIOR CIRCLE	-741	0	0	0	0	194.02
194.03	07953 FREE MEALS	0	0	0	0	0	194.03
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	27,536,749	5,627,137	2,916,878	202,174	500,821	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151318

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 ADMITTING						5.01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL						5.02
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	457,578					10.00
11.00	01100 CAFETERIA	0	319,465				11.00
13.00	01300 NURSING ADMINISTRATION	0	3,890	342,596			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	5,216	0	497,944		14.00
15.00	01500 PHARMACY	0	10,986	0	9,113	718,291	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	13,483	0	859	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	319,684	63,128	115,616	28,292	0	30.00
31.00	03100 INTENSIVE CARE UNIT	40,353	12,422	22,751	3,675	0	31.00
43.00	04300 NURSERY	0	1,746	3,198	823	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	18,788	34,409	74,125	0	50.00
51.00	05100 RECOVERY ROOM	0	9,173	16,800	4,562	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	31,564	0	28,498	0	54.00
54.01	05401 ULTRASOUND	0	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000 LABORATORY	0	33,730	0	106,608	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	13,351	0	7,168	0	65.00
66.00	06600 PHYSICAL THERAPY	0	155	0	2,109	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	79	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	115	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	4,863	0	1,298	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	80,030	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	115,346	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	718,291	73.00
76.00	03020 SLEEP LAB	0	4,310	0	1,417	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	8,643	0	7,127	0	90.00
91.00	09100 EMERGENCY	0	69,009	126,383	18,253	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0	12,798	23,439	8,224	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	360,037	317,255	342,596	497,721	718,291	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951 MARKETING	0	0	0	223	0	194.01
194.02	07952 SENIOR CIRCLE	0	2,210	0	0	0	194.02
194.03	07953 FREE MEALS	97,541	0	0	0	0	194.03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	457,578	319,465	342,596	497,944	718,291	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151318

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16 00	24 00	25 00	26 00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.01	00540					5.01
5.02	00560					5.02
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					13.00
14.00	01400					14.00
15.00	01500					15.00
16.00	01600	810,914				16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	44,694	4,781,707	0	4,781,707	30.00
31.00	03100	6,773	841,659	0	841,659	31.00
43.00	04300	2,928	129,775	0	129,775	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	103,871	2,316,557	0	2,316,557	50.00
51.00	05100	18,684	537,078	0	537,078	51.00
52.00	05200	0	0	0	0	52.00
53.00	05300	0	0	0	0	53.00
54.00	05400	148,161	2,728,112	0	2,728,112	54.00
54.01	05401	0	0	0	0	54.01
56.00	05600	0	0	0	0	56.00
57.00	05700	0	0	0	0	57.00
58.00	05800	0	0	0	0	58.00
60.00	06000	112,559	2,533,575	0	2,533,575	60.00
65.00	06500	10,564	680,527	0	680,527	65.00
66.00	06600	29,845	1,000,955	0	1,000,955	66.00
67.00	06700	9,373	356,003	0	356,003	67.00
68.00	06800	1,648	111,674	0	111,674	68.00
69.00	06900	26,618	351,010	0	351,010	69.00
71.00	07100	31,880	471,309	0	471,309	71.00
72.00	07200	18,500	738,013	0	738,013	72.00
73.00	07300	93,195	1,798,713	0	1,798,713	73.00
76.00	03020	5,940	291,654	0	291,654	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	3,753	495,209	0	495,209	90.00
91.00	09100	109,783	5,726,426	0	5,726,426	91.00
92.00	09200			0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	32,145	736,007	0	736,007	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		810,914	26,625,963	0	26,625,963	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	0	29,449	0	29,449	190.00
192.00	19200	0	611,050	0	611,050	192.00
194.00	07950	0	0	0	0	194.00
194.01	07951	0	171,277	0	171,277	194.01
194.02	07952	0	1,469	0	1,469	194.02
194.03	07953	0	97,541	0	97,541	194.03
200.00			0	0	0	200.00
201.00			0	0	0	201.00
202.00		810,914	27,536,749	0	27,536,749	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151318

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	2 00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	10,119	13,153	23,272
5.01	00540	ADMITTING	0	15,396	20,012	35,408
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	0	73,003	94,890	167,893
7.00	00700	OPERATION OF PLANT	0	424,330	551,545	975,875
8.00	00800	LAUNDRY & LINEN SERVICE	0	16,659	21,654	38,313
9.00	00900	HOUSEKEEPING	0	13,792	17,927	31,719
10.00	01000	DIETARY	0	34,821	45,261	80,082
11.00	01100	CAFETERIA	0	22,365	29,070	51,435
13.00	01300	NURSING ADMINISTRATION	0	6,504	8,454	14,958
14.00	01400	CENTRAL SERVICES & SUPPLY	0	34,132	44,364	78,496
15.00	01500	PHARMACY	0	15,933	20,710	36,643
16.00	01600	MEDICAL RECORDS & LIBRARY	0	28,796	37,430	66,226
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	0	239,023	310,684	549,707
31.00	03100	INTENSIVE CARE UNIT	0	27,700	36,005	63,705
43.00	04300	NURSERY	0	5,481	7,124	12,605
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	0	109,814	142,736	252,550
51.00	05100	RECOVERY ROOM	0	7,905	10,275	18,180
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	77,235	100,391	177,626
54.01	05401	ULTRASOUND	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0
60.00	06000	LABORATORY	0	30,880	40,138	71,018
65.00	06500	RESPIRATORY THERAPY	0	13,255	17,229	30,484
66.00	06600	PHYSICAL THERAPY	0	18,191	23,645	41,836
67.00	06700	OCCUPATIONAL THERAPY	0	5,952	7,737	13,689
68.00	06800	SPEECH PATHOLOGY	0	240	311	551
69.00	06900	ELECTROCARDIOLOGY	0	8,994	11,690	20,684
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0
76.00	03020	SLEEP LAB	0	12,841	16,691	29,532
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	0	8,348	10,851	19,199
91.00	09100	EMERGENCY	0	53,194	69,141	122,335
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	AMBULANCE SERVICES	0	21,421	27,843	49,264
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,336,324	1,736,961	3,073,285
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,858	0	5,858
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	91,739	119,243	210,982
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0
194.01	07951	MARKETING	0	0	0	0
194.02	07952	SENIOR CIRCLE	0	0	0	0
194.03	07953	FREE MEALS	0	0	0	0
200.00		Cross Foot Adjustments				0
201.00		Negative Cost Centers		0	0	0
202.00		TOTAL (sum lines 118-201)	0	1,433,921	1,856,204	3,290,125

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151318

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description		ADMITTING	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5 01	5 02	7 00	8 00	9 00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 ADMITTING	36,662					5.01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL	0	170,838				5.02
7.00	00700 OPERATION OF PLANT	0	18,096	994,440			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	923	18,184	57,420		8.00
9.00	00900 HOUSEKEEPING	0	2,833	15,054	0	50,085	9.00
10.00	01000 DIETARY	0	2,024	38,008	0	1,980	10.00
11.00	01100 CAFETERIA	0	1,459	24,411	0	1,272	11.00
13.00	01300 NURSING ADMINISTRATION	0	1,949	7,099	0	370	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	2,258	37,255	0	1,941	14.00
15.00	01500 PHARMACY	0	3,959	17,391	0	906	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	4,268	31,431	0	1,638	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	2,019	20,031	260,896	22,794	13,593	30.00
31.00	03100 INTENSIVE CARE UNIT	306	4,010	30,235	1,398	1,575	31.00
43.00	04300 NURSERY	132	623	5,982	0	312	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	4,693	10,160	119,862	9,528	6,246	50.00
51.00	05100 RECOVERY ROOM	844	2,842	8,628	0	450	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	6,720	13,684	84,303	6,488	4,393	54.00
54.01	05401 ULTRASOUND	0	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000 LABORATORY	5,086	13,424	33,705	94	1,756	60.00
65.00	06500 RESPIRATORY THERAPY	477	3,719	14,468	0	754	65.00
66.00	06600 PHYSICAL THERAPY	1,348	5,585	19,856	0	1,035	66.00
67.00	06700 OCCUPATIONAL THERAPY	423	2,011	6,497	0	339	67.00
68.00	06800 SPEECH PATHOLOGY	74	676	261	0	14	68.00
69.00	06900 ELECTROCARDIOLOGY	1,203	1,764	9,817	0	512	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,440	2,230	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	836	3,748	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,211	6,124	0	0	0	73.00
76.00	03020 SLEEP LAB	268	1,405	14,016	1,438	730	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	170	2,756	9,112	0	475	90.00
91.00	09100 EMERGENCY	4,960	31,935	58,061	15,680	3,025	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	1,452	3,590	23,381	0	1,218	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	36,662	168,086	887,913	57,420	44,534	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	46	6,394	0	333	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	1,645	100,133	0	5,218	192.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951 MARKETING	0	1,061	0	0	0	194.01
194.02	07952 SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953 FREE MEALS	0	0	0	0	0	194.03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	36,662	170,838	994,440	57,420	50,085	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151318

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10 00	11 00	13 00	14 00	15 00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00560						5.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	122,278					10.00
11.00	01100	0	78,781				11.00
13.00	01300	0	959	25,756			13.00
14.00	01400	0	1,286	0	121,388		14.00
15.00	01500	0	2,709	0	2,221	64,568	15.00
16.00	01600	0	3,325	0	209	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	85,429	15,568	8,692	6,897	0	30.00
31.00	03100	10,783	3,063	1,710	896	0	31.00
43.00	04300	0	431	240	201	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	4,633	2,587	18,070	0	50.00
51.00	05100	0	2,262	1,263	1,112	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	7,784	0	6,947	0	54.00
54.01	05401	0	0	0	0	0	54.01
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	0	8,318	0	25,989	0	60.00
65.00	06500	0	3,292	0	1,747	0	65.00
66.00	06600	0	38	0	514	0	66.00
67.00	06700	0	0	0	19	0	67.00
68.00	06800	0	0	0	28	0	68.00
69.00	06900	0	1,199	0	316	0	69.00
71.00	07100	0	0	0	19,510	0	71.00
72.00	07200	0	0	0	28,121	0	72.00
73.00	07300	0	0	0	0	64,568	73.00
76.00	03020	0	1,063	0	345	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	2,131	0	1,737	0	90.00
91.00	09100	0	17,019	9,502	4,450	0	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	3,156	1,762	2,005	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		96,212	78,236	25,756	121,334	64,568	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	54	0	194.01
194.02	07952	0	545	0	0	0	194.02
194.03	07953	26,066	0	0	0	0	194.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		122,278	78,781	25,756	121,388	64,568	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151318

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	16.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00540 ADMITTING					5.01
5.02 00560 OTHER ADMINISTRATIVE AND GENERAL					5.02
7.00 00700 OPERATION OF PLANT					7.00
8.00 00800 LAUNDRY & LINEN SERVICE					8.00
9.00 00900 HOUSEKEEPING					9.00
10.00 01000 DIETARY					10.00
11.00 01100 CAFETERIA					11.00
13.00 01300 NURSING ADMINISTRATION					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY					14.00
15.00 01500 PHARMACY					15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	107,550				16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00 03000 ADULTS & PEDIATRICS	5,929	994,573	0	994,573	30.00
31.00 03100 INTENSIVE CARE UNIT	899	119,297	0	119,297	31.00
43.00 04300 NURSERY	388	21,011	0	21,011	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	13,780	443,066	0	443,066	50.00
51.00 05100 RECOVERY ROOM	2,479	38,561	0	38,561	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	19,626	329,138	0	329,138	54.00
54.01 05401 ULTRASOUND	0	0	0	0	54.01
56.00 05600 RADIOISOTOPE	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00 06000 LABORATORY	14,933	175,523	0	175,523	60.00
65.00 06500 RESPIRATORY THERAPY	1,401	57,026	0	57,026	65.00
66.00 06600 PHYSICAL THERAPY	3,959	74,175	0	74,175	66.00
67.00 06700 OCCUPATIONAL THERAPY	1,243	24,221	0	24,221	67.00
68.00 06800 SPEECH PATHOLOGY	219	1,823	0	1,823	68.00
69.00 06900 ELECTROCARDIOLOGY	3,531	39,280	0	39,280	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,229	27,409	0	27,409	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2,454	35,159	0	35,159	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	12,364	87,267	0	87,267	73.00
76.00 03020 SLEEP LAB	788	49,814	0	49,814	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000 CLINIC	498	36,591	0	36,591	90.00
91.00 09100 EMERGENCY	14,565	287,234	0	287,234	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00 09500 AMBULANCE SERVICES	4,265	90,518	0	90,518	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00 SUBTOTALS (SUM OF LINES 1-117)	107,550	2,931,686	0	2,931,686	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,631	0	12,631	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	317,978	0	317,978	192.00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01 07951 MARKETING	0	1,219	0	1,219	194.01
194.02 07952 SENIOR CIRCLE	0	545	0	545	194.02
194.03 07953 FREE MEALS	0	26,066	0	26,066	194.03
200.00 Cross Foot Adjustments		0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	107,550	3,290,125	0	3,290,125	202.00

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	Reconciliation	
	NEW BLDG & FIXT (SQUARE FEE T)	NEW MVBLE EQUIP (SQUAPE FEE T)				
	1 00	2 00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	197,538				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		196,731			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,394	1,394	11,405,908		4.00
5.01 00540	ADMITTING	2,121	2,121	614,875	111,020,460	5.01
5.02 00560	OTHER ADMINISTRATIVE AND GENERAL	10,057	10,057	1,443,527		-5,627,137
7.00 00700	OPERATION OF PLANT	58,456	58,456	229,835	0	0
8.00 00800	LAUNDRY & LINEN SERVICE	2,295	2,295	0	0	0
9.00 00900	HOUSEKEEPING	1,900	1,900	234,952	0	0
10.00 01000	DIETARY	4,797	4,797	90,242	0	0
11.00 01100	CAFETERIA	3,081	3,081	100,072	0	0
13.00 01300	NURSING ADMINISTRATION	896	896	206,417	0	0
14.00 01400	CENTRAL SERVICES & SUPPLY	4,702	4,702	74,603	0	0
15.00 01500	PHARMACY	2,195	2,195	362,447	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	3,967	3,967	222,037	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	32,928	32,928	1,479,423	6,119,060	0
31.00 03100	INTENSIVE CARE UNIT	3,816	3,816	351,450	927,278	0
43.00 04300	NURSERY	755	755	47,585	400,814	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	15,128	15,128	469,161	14,221,047	0
51.00 05100	RECOVERY ROOM	1,089	1,089	245,773	2,558,012	0
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	10,640	10,640	768,162	20,282,327	0
54.01 05401	ULTRASOUND	0	0	0	0	0
56.00 05600	RADIOISOTOPE	0	0	0	0	0
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
60.00 06000	LABORATORY	4,254	4,254	588,390	15,410,658	0
65.00 06500	RESPIRATORY THERAPY	1,826	1,826	335,065	1,446,328	0
66.00 06600	PHYSICAL THERAPY	2,506	2,506	2,109	4,086,122	0
67.00 06700	OCCUPATIONAL THERAPY	820	820	0	1,283,211	0
68.00 06800	SPEECH PATHOLOGY	33	33	0	225,610	0
69.00 06900	ELECTROCARDIOLOGY	1,239	1,239	124,441	3,644,265	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,364,794	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,532,917	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,759,421	0
76.00 03020	SLEEP LAB	1,769	1,769	112,342	813,277	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	1,150	1,150	251,360	513,820	0
91.00 09100	EMERGENCY	7,328	7,328	2,792,340	15,030,508	0
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	2,951	2,951	208,488	4,400,991	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	184,093	184,093	11,355,096	111,020,460	-5,627,137
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	807	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	12,638	12,638	0	0	0
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01 07951	MARKETING	0	0	50,812	0	0
194.02 07952	SENIOR CIRCLE	0	0	0	0	0
194.03 07953	FREE MEALS	0	0	0	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per wkst. B, Part I)	1,433,921	1,856,204	1,426,672	1,400,151	
203.00	Unit cost multiplier (wkst. B, Part I)	7.258963	9.435239	0.125082	0.012612	
204.00	Cost to be allocated (per wkst. B, Part II)			23,272	36,662	
205.00	Unit cost multiplier (wkst. B, Part II)			0.002040	0.000330	

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL (ACCUM COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUAPE FEE T)	DIETARY (MEALS SERVED)	
		5.02	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 ADMITTING						5.01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL	21,910,353					5.02
7.00	00700 OPERATION OF PLANT	2,320,831	125,510				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	118,424	2,295	173,986			8.00
9.00	00900 HOUSEKEEPING	363,348	1,900	0	121,315		9.00
10.00	01000 DIETARY	259,616	4,797	0	4,797	18,075	10.00
11.00	01100 CAFETERIA	187,093	3,081	0	3,081	0	11.00
13.00	01300 NURSING ADMINISTRATION	249,982	896	0	896	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	289,652	4,702	0	4,702	0	14.00
15.00	01500 PHARMACY	209,722	2,195	0	2,195	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	547,412	3,967	0	3,967	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	2,569,049	32,928	69,069	32,928	12,628	30.00
31.00	03100 INTENSIVE CARE UNIT	514,253	3,816	4,235	3,816	1,594	31.00
43.00	04300 NURSERY	79,897	755	0	755	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	1,303,114	15,128	28,871	15,128	0	50.00
51.00	05100 RECOVERY ROOM	364,453	1,089	0	1,089	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,755,092	10,640	19,659	10,640	0	54.00
54.01	05401 ULTRASOUND	0	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000 LABORATORY	1,721,736	4,254	285	4,254	0	60.00
65.00	06500 RESPIRATORY THERAPY	476,971	1,826	0	1,826	0	65.00
66.00	06600 PHYSICAL THERAPY	716,298	2,506	0	2,506	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	257,879	820	0	820	0	67.00
68.00	06800 SPEECH PATHOLOGY	86,733	33	0	33	0	68.00
69.00	06900 ELECTROCARDIOLOGY	226,222	1,239	0	1,239	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	285,958	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	480,709	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	785,493	0	0	0	0	73.00
76.00	03020 SLEEP LAB	180,223	1,769	4,357	1,769	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	353,440	1,150	0	1,150	0	90.00
91.00	09100 EMERGENCY	4,095,418	7,328	47,510	7,328	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	460,395	2,951	0	2,951	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	21,557,413	112,065	173,986	107,870	14,222	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,858	807	0	807	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	210,982	12,638	0	12,638	0	192.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951 MARKETING	136,100	0	0	0	0	194.01
194.02	07952 SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953 FREE MEALS	0	0	0	0	3,853	194.03
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)	5,627,137	2,916,878	202,174	500,821	457,578	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.256825	23.240204	1.162013	4.128269	25.315519	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	170,838	994,440	57,420	50,085	122,278	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.007797	7.923193	0.330027	0.412851	6.765035	205.00

Cost Center Description	CAFETERIA (FTE)	NURSING ADMINISTRATION (FTE NURS AREAS)	CENTRAL SERVICES & SUPPLY (COSTED REQ UIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
	11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 00540 ADMITTING						5.01
5.02 00560 OTHER ADMINISTRATIVE AND GENERAL						5.02
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	14,453					11.00
13.00 01300 NURSING ADMINISTRATION	176	8,463				13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	236	0	1,940,484			14.00
15.00 01500 PHARMACY	497	0	35,512	649,440		15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	610	0	3,347	0	111,020,460	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	2,856	2,856	110,253	0	6,119,060	30.00
31.00 03100 INTENSIVE CARE UNIT	562	562	14,323	0	927,278	31.00
43.00 04300 NURSERY	79	79	3,207	0	400,814	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	850	850	288,866	0	14,221,047	50.00
51.00 05100 RECOVERY ROOM	415	415	17,779	0	2,558,012	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,428	0	111,055	0	20,282,327	54.00
54.01 05401 ULTRASOUND	0	0	0	0	0	54.01
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00 06000 LABORATORY	1,526	0	415,450	0	15,410,658	60.00
65.00 06500 RESPIRATORY THERAPY	604	0	27,934	0	1,446,328	65.00
66.00 06600 PHYSICAL THERAPY	7	0	8,219	0	4,086,122	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	307	0	1,283,211	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	450	0	225,610	68.00
69.00 06900 ELECTROCARDIOLOGY	220	0	5,057	0	3,644,265	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	311,878	0	4,364,794	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	449,500	0	2,532,917	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	649,440	12,759,421	73.00
76.00 03020 SLEEP LAB	195	0	5,523	0	813,277	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	391	0	27,775	0	513,820	90.00
91.00 09100 EMERGENCY	3,122	3,122	71,132	0	15,030,508	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES	579	579	32,048	0	4,400,991	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00 SUBTOTALS (SUM OF LINES 1-117)	14,353	8,463	1,939,615	649,440	111,020,460	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 07951 MARKETING	0	0	869	0	0	194.01
194.02 07952 SENIOR CIRCLE	100	0	0	0	0	194.02
194.03 07953 FREE MEALS	0	0	0	0	0	194.03
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)	319,465	342,596	497,944	718,291	810,914	202.00
203.00 Unit cost multiplier (wkst. B, Part I)	22.103715	40.481626	0.256608	1.106016	0.007304	203.00
204.00 Cost to be allocated (per wkst. B, Part II)	78,781	25,756	121,388	64,568	107,550	204.00
205.00 Unit cost multiplier (wkst. B, Part II)	5.450841	3.043365	0.062556	0.099421	0.000969	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151318

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description		Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs
				Total Costs	RCE Disallowance	
		1 00	2 00	3 00	4 00	5 00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS	4,781,707		4,781,707	0	30.00
31.00	03100 INTENSIVE CARE UNIT	841,659		841,659	0	31.00
43.00	04300 NURSERY	129,775		129,775	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	2,316,557		2,316,557	0	50.00
51.00	05100 RECOVERY ROOM	537,078		537,078	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	52.00
53.00	05300 ANESTHESIOLOGY	0		0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,728,112		2,728,112	0	54.00
54.01	05401 ULTRASOUND	0		0	0	54.01
56.00	05600 RADIOISOTOPE	0		0	0	56.00
57.00	05700 CT SCAN	0		0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	58.00
60.00	06000 LABORATORY	2,533,575		2,533,575	0	60.00
65.00	06500 RESPIRATORY THERAPY	680,527	0	680,527	0	65.00
66.00	06600 PHYSICAL THERAPY	1,000,955	0	1,000,955	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	356,003	0	356,003	0	67.00
68.00	06800 SPEECH PATHOLOGY	111,674	0	111,674	0	68.00
69.00	06900 ELECTROCARDIOLOGY	351,010		351,010	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	471,309		471,309	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	738,013		738,013	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,798,713		1,798,713	0	73.00
76.00	03020 SLEEP LAB	291,654		291,654	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	495,209		495,209	0	90.00
91.00	09100 EMERGENCY	5,726,426		5,726,426	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	849,814		849,814	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES	736,007		736,007	0	95.00
200.00	Subtotal (see instructions)	27,475,777	0	27,475,777	0	200.00
201.00	Less Observation Beds	849,814		849,814	0	201.00
202.00	Total (see instructions)	26,625,963	0	26,625,963	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151318

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/30/2014 1:53 pm

		Title XVIII			Hospital	Cost	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col 6 + col 7)			
		6.00	7.00	8.00	9.00	10.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	4,679,596		4,679,596			30.00
31.00	03100 INTENSIVE CARE UNIT	927,278		927,278			31.00
43.00	04300 NURSERY	400,814		400,814			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	3,736,621	10,484,426	14,221,047	0.162896	0.000000	50.00
51.00	05100 RECOVERY ROOM	534,993	2,023,019	2,558,012	0.209959	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,069,776	17,212,551	20,282,327	0.134507	0.000000	54.00
54.01	05401 ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600 RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700 CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
60.00	06000 LABORATORY	3,905,690	11,504,968	15,410,658	0.164404	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	1,142,008	304,320	1,446,328	0.470521	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	594,247	3,491,875	4,086,122	0.244965	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	570,923	712,288	1,283,211	0.277431	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	47,600	178,010	225,610	0.494987	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	1,161,090	2,483,175	3,644,265	0.096318	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,718,820	2,645,974	4,364,794	0.107980	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1,326,334	1,206,583	2,532,917	0.291369	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	6,585,964	6,173,457	12,759,421	0.140971	0.000000	73.00
76.00	03020 SLEEP LAB	27,442	785,835	813,277	0.358616	0.000000	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	6,586	507,234	513,820	0.963779	0.000000	90.00
91.00	09100 EMERGENCY	1,161,665	13,868,843	15,030,508	0.380987	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	137,321	1,302,143	1,439,464	0.590368	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0	4,400,991	4,400,991	0.167237	0.000000	95.00
200.00	Subtotal (see instructions)	31,734,768	79,285,692	111,020,460			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	31,734,768	79,285,692	111,020,460			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151318

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

Worksheet C  
Part I  
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>		11.00			
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401 ULTRASOUND	0.000000			54.01
56.00	05600 RADIOISOTOPE	0.000000			56.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03020 SLEEP LAB	0.000000			76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
200.00	Subtotal (see instructions)				200.00
201.00	Less observation beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151318

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description		Total Cost (from Wkst B, Part I, col 26)	Therapy Limit Adj.	Title XIX		Hospital		PPS
				Total Costs	RCE Disallowance	Total Costs		
		1 00	2 00	3 00	4.00	5 00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000 ADULTS & PEDIATRICS	4,781,707		4,781,707	0	4,781,707		30.00
31.00	03100 INTENSIVE CARE UNIT	841,659		841,659	0	841,659		31.00
43.00	04300 NURSERY	129,775		129,775	0	129,775		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000 OPERATING ROOM	2,316,557		2,316,557	0	2,316,557		50.00
51.00	05100 RECOVERY ROOM	537,078		537,078	0	537,078		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0		0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,728,112		2,728,112	0	2,728,112		54.00
54.01	05401 ULTRASOUND	0		0	0	0		54.01
56.00	05600 RADIOISOTOPE	0		0	0	0		56.00
57.00	05700 CT SCAN	0		0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0		58.00
60.00	06000 LABORATORY	2,533,575		2,533,575	0	2,533,575		60.00
65.00	06500 RESPIRATORY THERAPY	680,527	0	680,527	0	680,527		65.00
66.00	06600 PHYSICAL THERAPY	1,000,955	0	1,000,955	0	1,000,955		66.00
67.00	06700 OCCUPATIONAL THERAPY	356,003	0	356,003	0	356,003		67.00
68.00	06800 SPEECH PATHOLOGY	111,674	0	111,674	0	111,674		68.00
69.00	06900 ELECTROCARDIOLOGY	351,010		351,010	0	351,010		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	471,309		471,309	0	471,309		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	738,013		738,013	0	738,013		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,798,713		1,798,713	0	1,798,713		73.00
76.00	03020 SLEEP LAB	291,654		291,654	0	291,654		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000 CLINIC	495,209		495,209	0	495,209		90.00
91.00	09100 EMERGENCY	5,726,426		5,726,426	0	5,726,426		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	849,814		849,814	0	849,814		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500 AMBULANCE SERVICES	736,007		736,007	0	736,007		95.00
200.00	Subtotal (see instructions)	27,475,777	0	27,475,777	0	27,475,777		200.00
201.00	Less Observation Beds	849,814		849,814	0	849,814		201.00
202.00	Total (see instructions)	26,625,963	0	26,625,963	0	26,625,963		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151318

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

Worksheet C  
Part I  
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		Title XIX			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	10 00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	4,679,596		4,679,596	30.00
31.00	03100	INTENSIVE CARE UNIT	927,278		927,278	31.00
43.00	04300	NURSERY	400,814		400,814	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	3,736,621	10,484,426	14,221,047	0.162896 50.00
51.00	05100	RECOVERY ROOM	534,993	2,023,019	2,558,012	0.209959 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,069,776	17,212,551	20,282,327	0.134507 54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000 54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000 56.00
57.00	05700	CT SCAN	0	0	0	0.000000 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000 58.00
60.00	06000	LABORATORY	3,905,690	11,504,968	15,410,658	0.164404 60.00
65.00	06500	RESPIRATORY THERAPY	1,142,008	304,320	1,446,328	0.470521 65.00
66.00	06600	PHYSICAL THERAPY	594,247	3,491,875	4,086,122	0.244965 66.00
67.00	06700	OCCUPATIONAL THERAPY	570,923	712,288	1,283,211	0.277431 67.00
68.00	06800	SPEECH PATHOLOGY	47,600	178,010	225,610	0.494987 68.00
69.00	06900	ELECTROCARDIOLOGY	1,161,090	2,483,175	3,644,265	0.096318 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,718,820	2,645,974	4,364,794	0.107980 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,326,334	1,206,583	2,532,917	0.291369 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,585,964	6,173,457	12,759,421	0.140971 73.00
76.00	03020	SLEEP LAB	27,442	785,835	813,277	0.358616 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	6,586	507,234	513,820	0.963779 90.00
91.00	09100	EMERGENCY	1,161,665	13,868,843	15,030,508	0.380987 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	137,321	1,302,143	1,439,464	0.590368 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	AMBULANCE SERVICES	0	4,400,991	4,400,991	0.167237 95.00
200.00		Subtotal (see instructions)	31,734,768	79,285,692	111,020,460	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	31,734,768	79,285,692	111,020,460	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151318

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	PPS
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.162896			50.00
51.00	05100 RECOVERY ROOM	0.209959			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.134507			54.00
54.01	05401 ULTRASOUND	0.000000			54.01
56.00	05600 RADIOISOTOPE	0.000000			56.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000 LABORATORY	0.164404			60.00
65.00	06500 RESPIRATORY THERAPY	0.470521			65.00
66.00	06600 PHYSICAL THERAPY	0.244965			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.277431			67.00
68.00	06800 SPEECH PATHOLOGY	0.494987			68.00
69.00	06900 ELECTROCARDIOLOGY	0.096318			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.107980			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.291369			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.140971			73.00
76.00	03020 SLEEP LAB	0.358616			76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.963779			90.00
91.00	09100 EMERGENCY	0.380987			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.590368			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES	0.167237			95.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 151318

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

Worksheet C Part II Date/Time Prepared: 5/30/2014 1:53 pm

Cost Center Description	Title XIX			Hospital		PPS
	Total Cost (wkst. B, Part I, col. 26)	Capital Cost (wkst. E, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
	1 00	2 00	3 00	4 00	5 00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	2,316,557	443,066	1,873,491	0	0 50.00
51.00	05100 RECOVERY ROOM	537,078	38,561	498,517	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,728,112	329,138	2,398,974	0	0 54.00
54.01	05401 ULTRASOUND	0	0	0	0	0 54.01
56.00	05600 RADIOISOTOPE	0	0	0	0	0 56.00
57.00	05700 CT SCAN	0	0	0	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
60.00	06000 LABORATORY	2,533,575	175,523	2,358,052	0	0 60.00
65.00	06500 RESPIRATORY THERAPY	680,527	57,026	623,501	0	0 65.00
66.00	06600 PHYSICAL THERAPY	1,000,955	74,175	926,780	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	356,003	24,221	331,782	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	111,674	1,823	109,851	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	351,010	39,280	311,730	0	0 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	471,309	27,409	443,900	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	738,013	35,159	702,854	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,798,713	87,267	1,711,446	0	0 73.00
76.00	03020 SLEEP LAB	291,654	49,814	241,840	0	0 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	495,209	36,591	458,618	0	0 90.00
91.00	09100 EMERGENCY	5,726,426	287,234	5,439,192	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	849,814	0	849,814	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES	736,007	90,518	645,489	0	0 95.00
200.00	Subtotal (sum of lines 50 thru 199)	21,722,636	1,796,805	19,925,831	0	0 200.00
201.00	Less Observation Beds	849,814	0	849,814	0	0 201.00
202.00	Total (line 200 minus line 201)	20,872,822	1,796,805	19,076,017	0	0 202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 151318

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

Worksheet C  
Part II  
Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	2,316,557	14,221,047	0.162896		50.00
51.00	05100 RECOVERY ROOM	537,078	2,558,012	0.209959		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,728,112	20,282,327	0.134507		54.00
54.01	05401 ULTRASOUND	0	0	0.000000		54.01
56.00	05600 RADIOISOTOPE	0	0	0.000000		56.00
57.00	05700 CT SCAN	0	0	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000		58.00
60.00	06000 LABORATORY	2,533,575	15,410,658	0.164404		60.00
65.00	06500 RESPIRATORY THERAPY	680,527	1,446,328	0.470521		65.00
66.00	06600 PHYSICAL THERAPY	1,000,955	4,086,122	0.244965		66.00
67.00	06700 OCCUPATIONAL THERAPY	356,003	1,283,211	0.277431		67.00
68.00	06800 SPEECH PATHOLOGY	111,674	225,610	0.494987		68.00
69.00	06900 ELECTROCARDIOLOGY	351,010	3,644,265	0.096318		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	471,309	4,364,794	0.107980		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	738,013	2,532,917	0.291369		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,798,713	12,759,421	0.140971		73.00
76.00	03020 SLEEP LAB	291,654	813,277	0.358616		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	495,209	513,820	0.963779		90.00
91.00	09100 EMERGENCY	5,726,426	15,030,508	0.380987		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	849,814	1,439,464	0.590368		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES	736,007	4,400,991	0.167237		95.00
200.00	Subtotal (sum of lines 50 thru 199)	21,722,636	105,012,772			200.00
201.00	Less Observation Beds	849,814	0			201.00
202.00	Total (line 200 minus line 201)	20,872,822	105,012,772			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151318

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

Worksheet D  
Part II  
Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description		Capital Related Cost (from Wkst 3, 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)	Cost
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	443,066	14,221,047	0.031156	1,019,601	31,767	50.00
51.00	05100 RECOVERY ROOM	38,561	2,558,012	0.015075	169,081	2,549	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	329,138	20,282,327	0.016228	1,360,742	22,082	54.00
54.01	05401 ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
60.00	06000 LABORATORY	175,523	15,410,658	0.011390	1,842,973	20,991	60.00
65.00	06500 RESPIRATORY THERAPY	57,026	1,446,328	0.039428	668,422	26,355	65.00
66.00	06600 PHYSICAL THERAPY	74,175	4,086,122	0.018153	182,691	3,316	66.00
67.00	06700 OCCUPATIONAL THERAPY	24,221	1,283,211	0.018875	205,695	3,882	67.00
68.00	06800 SPEECH PATHOLOGY	1,823	225,610	0.008080	32,261	261	68.00
69.00	06900 ELECTROCARDIOLOGY	39,280	3,644,265	0.010779	641,277	6,912	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	27,409	4,364,794	0.006280	863,694	5,424	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	35,159	2,532,917	0.013881	810,606	11,252	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	87,267	12,759,421	0.006839	3,311,406	22,647	73.00
76.00	03020 SLEEP LAB	49,814	813,277	0.061251	16,192	992	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	36,591	513,820	0.071214	1,015	72	90.00
91.00	09100 EMERGENCY	287,234	15,030,508	0.019110	5,368	103	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,439,464	0.000000	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	1,706,287	100,611,781		11,131,024	158,605	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151318

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description	Title XVIII				Hospital	Cost
	Non Physician Anesthetic Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401 ULTRASOUND	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000 LABORATORY	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020 SLEEP LAB	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151318

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description		Title XVIII			Hospital		
		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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	14,221,047	0.000000	0.000000	1,019,601	50.00
51.00	05100 RECOVERY ROOM	0	2,558,012	0.000000	0.000000	169,081	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	20,282,327	0.000000	0.000000	1,360,742	54.00
54.01	05401 ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
60.00	06000 LABORATORY	0	15,410,658	0.000000	0.000000	1,842,973	60.00
65.00	06500 RESPIRATORY THERAPY	0	1,446,328	0.000000	0.000000	668,422	65.00
66.00	06600 PHYSICAL THERAPY	0	4,086,122	0.000000	0.000000	182,691	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,283,211	0.000000	0.000000	205,695	67.00
68.00	06800 SPEECH PATHOLOGY	0	225,610	0.000000	0.000000	32,261	68.00
69.00	06900 ELECTROCARDIOLOGY	0	3,644,265	0.000000	0.000000	641,277	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,364,794	0.000000	0.000000	863,694	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	2,532,917	0.000000	0.000000	810,606	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	12,759,421	0.000000	0.000000	3,311,406	73.00
76.00	03020 SLEEP LAB	0	813,277	0.000000	0.000000	16,192	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	513,820	0.000000	0.000000	1,015	90.00
91.00	09100 EMERGENCY	0	15,030,508	0.000000	0.000000	5,368	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,439,464	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	100,611,781			11,131,024	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS  
 Provider CCN: 151318  
 Period: From 01/01/2013 To 12/31/2013  
 Worksheet D Part IV Date/Time Prepared: 5/30/2014 1:53 pm

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	Cost
		11.00	12.00	13.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401 ULTRASOUND	0	0	0		54.01
56.00	05600 RADIOISOTOPE	0	0	0		56.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000 LABORATORY	0	0	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020 SLEEP LAB	0	0	0		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES	0	0	0		95.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151318		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part V Date/Time Prepared: 5/30/2014 1:53 pm	
		Title XVIII		Hospital		Cost	
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col 9	PPS Reimbursed Services (see Inst.)	Charges		Costs		
			Cost Reimbursed Subject To Ded. & Coins (see Inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins (see Inst.)	PPS Services (see Inst.)		
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.162896	0	2,587,650	0	0	50.00
51.00	05100 RECOVERY ROOM	0.209959	0	538,945	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.134507	0	5,544,329	0	0	54.00
54.01	05401 ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000 LABORATORY	0.164404	0	4,310,408	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.470521	0	151,183	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.244965	0	1,384,951	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.277431	0	215,731	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.494987	0	68,642	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.096318	0	1,130,260	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.107980	0	539,091	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.291369	0	526,154	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.140971	0	2,506,017	0	0	73.00
76.00	03020 SLEEP LAB	0.358616	0	202,623	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.963779	0	53,083	0	0	90.00
91.00	09100 EMERGENCY	0.380987	0	3,873,590	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.590368	0	577,206	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0.167237		0			95.00
200.00	Subtotal (see instructions)		0	24,209,863	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	24,209,863	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151318

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

Worksheet D  
Part V  
Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description		Costs		Hospital	Cost
		Cost Reimbursed Services Subject To Ded. & Coins (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins (see inst.)		
		6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	421,518	0		50.00
51.00	05100 RECOVERY ROOM	113,156	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	745,751	0		54.00
54.01	05401 ULTRASOUND	0	0		54.01
56.00	05600 RADIOISOTOPE	0	0		56.00
57.00	05700 CT SCAN	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000 LABORATORY	708,648	0		60.00
65.00	06500 RESPIRATORY THERAPY	71,135	0		65.00
66.00	06600 PHYSICAL THERAPY	339,265	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	59,850	0		67.00
68.00	06800 SPEECH PATHOLOGY	33,977	0		68.00
69.00	06900 ELECTROCARDIOLOGY	108,864	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	58,211	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	153,305	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	353,276	0		73.00
76.00	03020 SLEEP LAB	72,664	0		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	51,160	0		90.00
91.00	09100 EMERGENCY	1,475,787	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	340,764	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES	0	0		95.00
200.00	Subtotal (see instructions)	5,107,331	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)	5,107,331	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151318

Period: From 01/01/2013

Worksheet D

Component CCN: 152318

To 12/31/2013

Part V

Date/Time Prepared: 5/30/2014 1:53 pm

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Cost to Charge Ratio From worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded & Coins (see inst.)	Cost Reimbursed Services No. Subject To Ded & Coins (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0.162896	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0.209959	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.134507	0	0	0	0	54.00
54.01 05401 ULTRASOUND	0.000000	0	0	0	0	54.01
56.00 05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00 05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00 06000 LABORATORY	0.164404	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.470521	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.244965	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.277431	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.494987	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.096318	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.107980	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.291369	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.140971	0	0	0	0	73.00
76.00 03020 SLEEP LAB	0.358616	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0.963779	0	0	0	0	90.00
91.00 09100 EMERGENCY	0.380987	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.590368	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES	0.167237		0	0		95.00
200.00	Subtotal (see instructions)		0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151318 Component CCN: 15Z318	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/30/2014 1:53 pm
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Cost Center Description	Costs		Swing Beds - SNF	Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401 ULTRASOUND	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020 SLEEP LAB	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0	0	95.00
200.00	Subtotal (see instructions)	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 151318

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

Worksheet D  
Part I  
Date/Time Prepared:  
5/30/2014 1:53 pm

		Title XIX		Hospital	PPS	
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)	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS	994,573	125,500	869,073	3,781	229.85 30.00
31.00	INTENSIVE CARE UNIT	119,297		119,297	545	218.89 31.00
43.00	NURSERY	21,011		21,011	449	46.80 43.00
200.00	Total (lines 30-199)	1,134,881		1,009,381	4,775	200.00
Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS	123	28,272	30.00		
31.00	INTENSIVE CARE UNIT	62	13,571	31.00		
43.00	NURSERY	57	2,668	43.00		
200.00	Total (lines 30-199)	242	44,511	200.00		

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151318

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

Worksheet D  
Part II  
Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description		Title XIX				Hospital		PPS
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (From Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 - col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000 OPERATING ROOM	443,066	14,221,047	0.031156	230,201	7,172	50.00	
51.00	05100 RECOVERY ROOM	38,561	2,558,012	0.015075	36,706	553	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00	
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	329,138	20,282,327	0.016228	228,561	3,709	54.00	
54.01	05401 ULTRASOUND	0	0	0.000000	0	0	54.01	
56.00	05600 RADIOISOTOPE	0	0	0.000000	0	0	56.00	
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00	
60.00	06000 LABORATORY	175,523	15,410,658	0.011390	246,922	2,812	60.00	
65.00	06500 RESPIRATORY THERAPY	57,026	1,446,328	0.039428	69,049	2,722	65.00	
66.00	06600 PHYSICAL THERAPY	74,175	4,086,122	0.018153	11,179	203	66.00	
67.00	06700 OCCUPATIONAL THERAPY	24,221	1,283,211	0.018875	3,729	70	67.00	
68.00	06800 SPEECH PATHOLOGY	1,823	225,610	0.008080	599	5	68.00	
69.00	06900 ELECTROCARDIOLOGY	39,280	3,644,265	0.010779	88,964	959	69.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	27,409	4,364,794	0.006280	130,264	818	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	35,159	2,532,917	0.013881	19,471	270	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	87,267	12,759,421	0.006839	433,834	2,967	73.00	
76.00	03020 SLEEP LAB	49,814	813,277	0.061251	1,989	122	76.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000 CLINIC	36,591	513,820	0.071214	195	14	90.00	
91.00	09100 EMERGENCY	287,234	15,030,508	0.019110	125,037	2,389	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	202,282	1,439,464	0.140526	2,969	417	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500 AMBULANCE SERVICES						95.00	
200.00	Total (lines 50-199)	1,908,569	100,611,781		1,629,669	25,202	200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS      Provider CCN: 151318      Period: From 01/01/2013 To 12/31/2013      Worksheet D Part III Date/Time Prepared: 5/30/2014 1:53 pm

Cost Center Description		Title XIX			Hospital	PPS	Total Costs (sum of cols 1 through 3, minus col 4)
		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	5 00	
		1 00	2 00	3 00	4 00	5 00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0 30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
43.00	04300	NURSERY	0	0	0	0	0 43.00
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		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	3,781	0.00	123	0	30.00
31.00	03100	INTENSIVE CARE UNIT	545	0.00	62	0	31.00
43.00	04300	NURSERY	449	0.00	57	0	43.00
200.00		Total (lines 30-199)	4,775		242	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151318

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description	Title XIX				Hospital	PPS
	Non Physician Anesthetic Cost	Nursing School	Allied Health	All other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01 05401 ULTRASOUND	0	0	0	0	0	54.01
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03020 SLEEP LAB	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHEK REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151318

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description		Total Outpatient Cost (sum of col 2, 3 and 4)	Total Charges (from Wkst C, Part I, col 8)	Ratio of Cost to Charges (col 5 - col 7)	Outpatient Ratio of Cost to Charges (col 6 - col 7)	Inpatient Program Charges	PPS
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	14,221,047	0.000000	0.000000	230,201	50.00
51.00	05100 RECOVERY ROOM	0	2,558,012	0.000000	0.000000	36,706	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	20,282,327	0.000000	0.000000	228,561	54.00
54.01	05401 ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
60.00	06000 LABORATORY	0	15,410,658	0.000000	0.000000	246,922	60.00
65.00	06500 RESPIRATORY THERAPY	0	1,446,328	0.000000	0.000000	69,049	65.00
66.00	06600 PHYSICAL THERAPY	0	4,086,122	0.000000	0.000000	11,179	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,283,211	0.000000	0.000000	3,729	67.00
68.00	06800 SPEECH PATHOLOGY	0	225,610	0.000000	0.000000	599	68.00
69.00	06900 ELECTROCARDIOLOGY	0	3,644,265	0.000000	0.000000	88,964	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,364,794	0.000000	0.000000	130,264	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	2,532,917	0.000000	0.000000	19,471	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	12,759,421	0.000000	0.000000	433,834	73.00
76.00	03020 SLEEP LAB	0	813,277	0.000000	0.000000	1,989	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	513,820	0.000000	0.000000	195	90.00
91.00	09100 EMERGENCY	0	15,030,508	0.000000	0.000000	125,037	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,439,464	0.000000	0.000000	2,969	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0					95.00
200.00	Total (lines 50-199)	0	100,611,781			1,629,669	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151318

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description		Inpatient Program Pass-Through Costs (col 8 x col 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col 9 x col 12)	Hospital	PPS
		11.00	12.00	13.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401 ULTRASOUND	0	0	0		54.01
56.00	05600 RADIOISOTOPE	0	0	0		56.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000 LABORATORY	0	0	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020 SLEEP LAB	0	0	0		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES	0	0	0		95.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151318	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/30/2014 1:53 pm
Title XIX		Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
		PPS Reimbursed Services (see Inst.)	Cost Reimbursed Services Subject To Ded. & Coins (see Inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins (see Inst.)	PPS Services (see Inst.)		
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.162896	0	330,799	0	0	50.00
51.00	05100 RECOVERY ROOM	0.209959	0	63,648	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.134507	0	1,222,590	0	0	54.00
54.01	05401 ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000 LABORATORY	0.164404	0	795,112	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.470521	0	24,752	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.244965	0	114,448	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.277431	0	48,322	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.494987	0	7,874	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.096318	0	136,587	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.107980	0	76,267	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.291369	0	3,464	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.140971	0	385,490	0	0	73.00
76.00	03020 SLEEP LAB	0.358616	0	100,330	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.963779	0	12,518	0	0	90.00
91.00	09100 EMERGENCY	0.380987	0	1,186,260	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.590368	0	100,744	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0.167237	0	400,716	0	0	95.00
200.00	Subtotal (see instructions)		0	5,009,921	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	5,009,921	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151318

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

Worksheet D  
Part V  
Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description		Costs		Title XIX	Hospital	PPS
		Cost Reimbursed Services Subject To Ded. & Coins (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins (see inst.)			
		6.00	7.00			
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	53,886	0			50.00
51.00	05100 RECOVERY ROOM	13,363	0			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			52.00
53.00	05300 ANESTHESIOLOGY	0	0			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	164,447	0			54.00
54.01	05401 ULTRASOUND	0	0			54.01
56.00	05600 RADIOISOTOPE	0	0			56.00
57.00	05700 CT SCAN	0	0			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
60.00	06000 LABORATORY	130,720	0			60.00
65.00	06500 RESPIRATORY THERAPY	11,646	0			65.00
66.00	06600 PHYSICAL THERAPY	28,036	0			66.00
67.00	06700 OCCUPATIONAL THERAPY	13,406	0			67.00
68.00	06800 SPEECH PATHOLOGY	3,898	0			68.00
69.00	06900 ELECTROCARDIOLOGY	13,156	0			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8,235	0			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1,009	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	54,343	0			73.00
76.00	03020 SLEEP LAB	35,980	0			76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	12,065	0			90.00
91.00	09100 EMERGENCY	451,950	0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	59,476	0			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES	67,015	0			95.00
200.00	Subtotal (see instructions)	1,122,631	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)	1,122,631	0			202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151318

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

Worksheet D-1

Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description		Title XVIII	Hospital	Cost	
				1.00	
<b>PART I - ALL PROVIDER COMPONENTS</b>					
<b>INPATIENT DAYS</b>					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			4,327	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,781	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			3,012	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			546	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)			1,670	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)			493	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
<b>SWING BED ADJUSTMENT</b>					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)			4,781,707	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)			603,379	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			4,178,328	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>					
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)			4,178,328	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>					
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,105.09	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,845,500	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			1,845,500	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151318

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

Worksheet D-1  
Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 - col. 2)	Hospital Program Days	Program Cost (col. 3 x col. 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00	INTENSIVE CARE UNIT	841,659	545	1,544.33	265	409,247	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
<b>Cost Center Description</b>							
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					1,986,761	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,241,508	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00	Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					544,809	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)					544,809	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00	Total observation bed days (see instructions)					769	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,105.09	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					849,814	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151318

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

Worksheet D-1

Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description	Title XVIII		Hospital		Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
	Cost	Routine Cost (from line 27)	column 1 - column 2	Total Observation Bed Cost (from line 89)	
	1.00	2.00	3.00	4.00	5.00
<b>COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>					
90.00 Capital-related cost	0	0	0.000000	0	0 90.00
91.00 Nursing School cost	0	0	0.000000	0	0 91.00
92.00 Allied health cost	0	0	0.000000	0	0 92.00
93.00 All other Medical Education	0	0	0.000000	0	0 93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151318

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

Worksheet D-1  
Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description		Title XIX	Hospital	PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			4,327 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,781 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			3,012 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			546 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)			123 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)			449 15.00
16.00	Nursery days (title V or XIX only)			57 16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			4,781,707 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)			603,379 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			4,178,328 27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)			4,178,328 37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,105.09 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			135,926 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)			135,926 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151318

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

Worksheet D-1  
Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description	Title XIX			Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col 1 - col 2)	Program Days	Program Cost (col 3 x col 4)	
42.00 NURSERY (title V & XIX only)	129,775	449	289.03	57	16,475	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>						
43.00 INTENSIVE CARE UNIT	841,659	545	1,544.33	62	95,748	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
<b>Cost Center Description</b>						
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					292,859	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					541,008	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					44,511	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					25,202	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					69,713	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					471,295	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable inpatient cost plus incentive payment (see instructions)					0	63.00
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>						
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>						
87.00 Total observation bed days (see instructions)					769	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,105.09	88.00
89.00 observation bed cost (line 87 x line 88) (see instructions)					849,814	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151318		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/30/2014 1:53 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 - column 2	Hospital Total Observation Bed Cost (from line 89)	PPS Observation Bed Pass Through Cost (col 3 x col 4) (see instructions)	
		1 00	2 00	3 00	4 00	5 00	
<b>COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
90.00	Capital-related cost	994,573	4,178,328	0.238031	849,814	202,282	90.00
91.00	Nursing School cost	0	4,178,328	0.000000	849,814	0	91.00
92.00	Allied health cost	0	4,178,328	0.000000	849,814	0	92.00
93.00	All other Medical Education	0	4,178,328	0.000000	849,814	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151318

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

Worksheet D-3

Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	Inpatient Program Costs (col 1 x col 2)	Cost
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		2,254,975		30.00
31.00	03100 INTENSIVE CARE UNIT		539,435		31.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.162896	1,019,601	166,089	50.00
51.00	05100 RECOVERY ROOM	0.209959	169,081	35,500	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.134507	1,360,742	183,029	54.00
54.01	05401 ULTRASOUND	0.000000	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.164404	1,842,973	302,992	60.00
65.00	06500 RESPIRATORY THERAPY	0.470521	668,422	314,507	65.00
66.00	06600 PHYSICAL THERAPY	0.244965	182,691	44,753	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.277431	205,695	57,066	67.00
68.00	06800 SPEECH PATHOLOGY	0.494987	32,261	15,969	68.00
69.00	06900 ELECTROCARDIOLOGY	0.096318	641,277	61,767	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.107980	863,694	93,262	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.291369	810,606	236,185	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.140971	3,311,406	466,812	73.00
76.00	03020 SLEEP LAB	0.358616	16,192	5,807	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.963779	1,015	978	90.00
91.00	09100 EMERGENCY	0.380987	5,368	2,045	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.590368	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		11,131,024	1,986,761	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)		11,131,024		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151318  
Component CCN: 152318

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

Worksheet D-3  
Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.162896	0	0	50.00
51.00	05100 RECOVERY ROOM	0.209959	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.134507	15,505	2,086	54.00
54.01	05401 ULTRASOUND	0.000000	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.164404	47,982	7,888	60.00
65.00	06500 RESPIRATORY THERAPY	0.470521	72,287	34,013	65.00
66.00	06600 PHYSICAL THERAPY	0.244965	299,252	73,306	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.277431	273,700	75,933	67.00
68.00	06800 SPEECH PATHOLOGY	0.494987	617	305	68.00
69.00	06900 ELECTROCARDIOLOGY	0.096318	1,557	150	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.107980	55,094	5,949	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.291369	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.140971	210,750	29,710	73.00
76.00	03020 SLEEP LAB	0.358616	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.963779	0	0	90.00
91.00	09100 EMERGENCY	0.380987	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.590368	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		976,744	229,340	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		976,744		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151318	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/30/2014 1:53 pm	
Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		196,154		30.00
31.00	03100 INTENSIVE CARE UNIT		105,676		31.00
43.00	04300 NURSERY		48,091		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.162896	230,201	37,499	50.00
51.00	05100 RECOVERY ROOM	0.209959	36,706	7,707	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.134507	228,561	30,743	54.00
54.01	05401 ULTRASOUND	0.000000	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.164404	246,922	40,595	60.00
65.00	06500 RESPIRATORY THERAPY	0.470521	69,049	32,489	65.00
66.00	06600 PHYSICAL THERAPY	0.244965	11,179	2,738	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.277431	3,729	1,035	67.00
68.00	06800 SPEECH PATHOLOGY	0.494987	599	296	68.00
69.00	06900 ELECTROCARDIOLOGY	0.096318	88,964	8,569	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.107980	130,264	14,066	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.291369	19,471	5,673	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.140971	433,834	61,158	73.00
76.00	03020 SLEEP LAB	0.358616	1,989	713	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.963779	195	188	90.00
91.00	09100 EMERGENCY	0.380987	125,037	47,637	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.590368	2,969	1,753	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		1,629,669	292,859	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		1,629,669		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151318	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/30/2014 1:53 pm
		Title XVIII	Hospital	Cost
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			5,107,331 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			5,107,331 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			5,158,404 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)			18,604 25.00
26.00	Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)			4,012,798 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			1,127,002 27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			1,127,002 30.00
31.00	Primary payer payments			730 31.00
32.00	Subtotal (line 30 minus line 31)			1,126,272 32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			860,303 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			757,067 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			799,596 36.00
37.00	Subtotal (see instructions)			1,883,339 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)			1,883,339 40.00
40.01	Sequestration adjustment (see instructions)			28,438 40.01
41.00	Interim payments			1,803,033 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			51,868 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151318

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/30/2014 1:53 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1 00	2 00	3 00	4 00		
1.00	Total interim payments paid to provider		2,819,832		1,803,033		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
<b>Program to Provider</b>							
3.01	ADJUSTMENTS TO PROVIDER	07/02/2013	262,200		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
<b>Provider to Program</b>							
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)		262,200		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)		3,082,032		1,803,033		4.00
<b>TO BE COMPLETED BY CONTRACTOR</b>							
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
<b>Program to Provider</b>							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
<b>Provider to Program</b>							
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		701,709		51,868		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		3,783,741		1,854,901		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
			0	1 00	2 00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151318  
Component CCN: 152318

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/30/2014 1:53 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1 00	2 00	3 00	4 00	
1.00	Total interim payments paid to provider		665,693		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
<b>Program to Provider</b>						
3.01	ADJUSTMENTS TO PROVIDER	07/02/2013	90,200		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
<b>Provider to Program</b>						
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)		90,200		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)		755,893		0	4.00
<b>TO BE COMPLETED BY CONTRACTOR</b>						
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
<b>Program to Provider</b>						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
<b>Provider to Program</b>						
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		13,753		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		769,646		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1 00	2 00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 151318	Period: From 01/01/2013 To 12/31/2013	Worksheet E-1 Part II Date/Time Prepared: 5/30/2014 1:53 pm
		Title XVIII	Hospital	Cost
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			1,098 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			1,935 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2			234 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			3,557 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			111,020,460 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			364,833 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology worksheet S-2, Part I line 168			255,899 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			207,739 8.00
9.00	Sequestration adjustment amount (see instructions)			4,155 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			203,584 10.00
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			203,584 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151318  
Component CCN: 15Z318

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

Worksheet E-2  
Date/Time Prepared:  
5/30/2014 1:53 pm

		Title XVIII		Swing Beds - SNF		Cost	
		Part A	Part B	Part A	Part B		
		1.00	2.00				
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>							
1.00	Inpatient routine services - swing bed-SNF (see instructions)	550,257	0			1.00	
2.00	Inpatient routine services - swing bed-NF (see instructions)						2.00
3.00	Ancillary services (from wkst. D-3, column 3, line 200 for Part A, and sum of wkst. D, Part V, columns 6 and 7, line 202 for Part B) (For CAH, see instructions)	231,633	0				3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00				4.00
5.00	Program days	493	0				5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0				6.00
7.00	Utilization review - physician compensation - SNF optional method only	0					7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	781,890	0				8.00
9.00	Primary payer payments (see instructions)	0	0				9.00
10.00	Subtotal (line 8 minus line 9)	781,890	0				10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0				11.00
12.00	Subtotal (line 10 minus line 11)	781,890	0				12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	444	0				13.00
14.00	80% of Part B costs (line 12 x 80%)		0				14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	781,446	0				15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0				16.00
17.00	Allowable bad debts (see instructions)	0	0				17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0				17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0				18.00
19.00	Total (see instructions)	781,446	0				19.00
19.01	Sequestration adjustment (see instructions)	11,800	0				19.01
20.00	Interim payments	755,893	0				20.00
21.00	Tentative settlement (for contractor use only)	0	0				21.00
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21	13,753	0				22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0				23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151318	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part V Date/Time Prepared: 5/30/2014 1:53 pm
		Title XVIII	Hospital	Cost
				1.00
<b>PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHS)</b>				
1.00	Inpatient services			4,241,508 1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 thru 3)			4,241,508 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			4,283,923 6.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
<b>Customary charges</b>				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 17.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
18.00	Direct graduate medical education payments (from worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			4,283,923 19.00
20.00	Deductibles (exclude professional component)			469,879 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			3,814,044 22.00
23.00	Coinurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			3,814,044 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			31,485 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			27,707 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			9,983 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			3,841,751 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (line 28, plus or minus lines 29)			3,841,751 30.00
30.01	Sequestration adjustment (see instructions)			58,010 30.01
31.00	Interim payments			3,082,032 31.00
32.00	Tentative settlement (for contractor use only)			0 32.00
33.00	Balance due provider/program line 30 minus lines 30.01, 31, and 32			701,709 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			553,040 34.00

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

Provider CCN: 151318

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

Worksheet G

Date/Time Prepared:  
5/30/2014 1:53 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund		
	1 00	2 00	3 00	4 00		
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	-39,476	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	8,284,541	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,987,442	0	0	0	6.00
7.00	Inventory	901,792	0	0	0	7.00
8.00	Prepaid expenses	252,312	0	0	0	8.00
9.00	Other current assets	233,282	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)	7,645,009	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	500,000	0	0	0	12.00
13.00	Land improvements	216,420	0	0	0	13.00
14.00	Accumulated depreciation	-53,556	0	0	0	14.00
15.00	Buildings	10,455,950	0	0	0	15.00
16.00	Accumulated depreciation	-1,875,045	0	0	0	16.00
17.00	Leasehold improvements	5,075,801	0	0	0	17.00
18.00	Accumulated depreciation	-852,406	0	0	0	18.00
19.00	Fixed equipment	1,157,088	0	0	0	19.00
20.00	Accumulated depreciation	-300,808	0	0	0	20.00
21.00	Automobiles and trucks	456,796	0	0	0	21.00
22.00	Accumulated depreciation	-293,917	0	0	0	22.00
23.00	Major movable equipment	5,431,116	0	0	0	23.00
24.00	Accumulated depreciation	-3,333,039	0	0	0	24.00
25.00	Minor equipment depreciable	1,261,620	0	0	0	25.00
26.00	Accumulated depreciation	-762,536	0	0	0	26.00
27.00	HIT designated Assets	2,294,361	0	0	0	27.00
28.00	Accumulated depreciation	-535,306	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)	18,842,539	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,073,300	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,073,300	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	28,560,848	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	928,913	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,284,456	0	0	0	38.00
39.00	Payroll taxes payable	102,202	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	401,162	0	0	0	43.00
44.00	Other current liabilities	711,751	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,428,484	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
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)	3,428,484	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	25,132,364	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)	25,132,364	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	28,560,848	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151318

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

Worksheet G-1

Date/Time Prepared:  
5/30/2014 1:53 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		18,720,840		0		1.00
2.00	Net income (loss) (from wkst. G-3, line 29)		6,411,525				2.00
3.00	Total (sum of line 1 and line 2)		25,132,365		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)		25,132,365		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)		25,132,365		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: 151318

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/30/2014 1:53 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1 00	2 00	3 00	
<b>PART I - PATIENT REVENUES</b>					
<b>General Inpatient Routine Services</b>					
1.00	Hospital	5,080,409		5,080,409	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)	5,080,409		5,080,409	10.00
<b>Intensive Care Type Inpatient Hospital Services</b>					
11.00	INTENSIVE CARE UNIT	927,278		927,278	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)	927,278		927,278	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,007,687		6,007,687	17.00
18.00	Ancillary services	24,421,509	59,206,481	83,627,990	18.00
19.00	Outpatient services	1,305,572	15,678,220	16,983,792	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	4,400,991	4,400,991	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	31,734,768	79,285,692	111,020,460	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		32,617,312		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)		32,617,312		43.00

## STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151318

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

Worksheet G-3

Date/Time Prepared:  
5/30/2014 1:53 pm

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	111,020,460	1.00
2.00	Less contractual allowances and discounts on patients' accounts	72,619,874	2.00
3.00	Net patient revenues (line 1 minus line 2)	38,400,586	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	32,617,312	4.00
5.00	Net income from service to patients (line 3 minus line 4)	5,783,274	5.00
<b>OTHER INCOME</b>			
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	63,430	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	11,582	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	2,467	21.00
22.00	Rental of hospital space	4,788	22.00
23.00	Governmental appropriations	0	23.00
24.00	HITECH INCENTIVE AND OTHER REVENUE	545,984	24.00
25.00	Total other income (sum of lines 6-24)	628,251	25.00
26.00	Total (line 5 plus line 25)	6,411,525	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)	6,411,525	29.00