

Parkview LaGrange Hospital

**Provider No. 15-1323, 15-Z323
and Aim No. 200524440**

**Hospital Statements of Reimbursable Costs
(Medicare and Medicaid Programs)**

December 31, 2013

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: 151323 Period: From 01/01/2013 To 12/31/2013 Worksheet S Parts I-III Date/Time Prepared: 5/27/2014 5:23 pm

PART I - COST REPORT STATUS

Provider use only 1. Electronically filed cost report Date: 5/27/2014 Time: 5:23 pm
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPITAL OF LAGRANGE COUNTY IN (151323) 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: 5/27/2014 Time: 5:23 pm
 Nk: cdCuPNAKz5WXFg0t3kHOR8suKdO
 s. ZJI 02UrSI VF5sMdZkVpDrT: vj z6t
 RdEB0xFXx80d7cIx
 PI: Date: 5/27/2014 Time: 5:23 pm
 mRpx9N: fESa6Q8oM7Ry: 2Qw1CmrBZO
 S3MqB068. YULVevkpNH1J80Swu. GCN
 o9w. 0l Unbw0gRzxH

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

 Title

 Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	26,342	9,327	361,264	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	77,027	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	103,369	9,327	361,264	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: 151323	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/27/2014 5:15 pm
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1.00 Hospital and Hospital Health Care Complex Address:		2.00		3.00		4.00				
1.00	Street: 207 NORTH TOWNLINE ROAD	PO Box:		Zip Code: 46761-1325		County: LAGRANGE				1.00
2.00	City: LAGRANGE	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			
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	COMMUNITY HOSPT. OF LAGRANGE CTY IN	151323	99915	1	05/01/2005	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	SWING BEDS	152323	99915		05/01/2005	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
17.10	Hospital-Based (CORF) I									17.10
17.20	Hospital-Based (OPT) I									17.20
17.30	Hospital-Based (OOT) I									17.30
17.40	Hospital-Based (OSP) I									17.40
18.00	Renal Dialysis									18.00
19.00	Other									19.00

						From:	To:		
						1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2013	12/31/2013	20.00	
21.00	Type of Control (see instructions)					2		21.00	

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

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00	0	0	0	0	0	0	24.00
25.00	0	0	0	0	0	0	25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151323	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/27/2014 5:15 pm		
		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	
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N		39.00	
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable.	N			57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.	N			58.00	
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00		
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151323

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

Worksheet S-2
Part I
Date/Time Prepared:
5/27/2014 5:15 pm

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))
				1.00	2.00	3.00
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151323	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/27/2014 5:15 pm			
		V 1.00	XIX 2.00				
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N				96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00				97.00
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y					105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N					106.00
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	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.	N	N	N	N		109.00
					1.00	2.00	3.00
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.			N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.			Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1			118.00
		Premiums 1.00		Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	32,174		1,184			0118.01
					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
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.			N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.						134.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151323		Period: From 01/01/2013 To 12/31/2013		Worksheet S-2 Part I Date/Time Prepared: 5/27/2014 5:15 pm		
		1.00	2.00					
All Providers								
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H032					140.00
		1.00	2.00	3.00				
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.								
141.00	Name: PARKVIEW HEALTH SYSTEM, INC.	Contractor's Name: WISCONSIN PHYSICIANS SERVICE		Contractor's Number: 08101				141.00
142.00	Street: 10501 CORPORATE DRIVE	PO Box: 5600						142.00
143.00	City: FORT WAYNE	State: IN	Zip Code: 46845					143.00
						1.00		
144.00	Are provider based physicians' costs included in worksheet A?	Y						144.00
145.00	If costs for renal services are claimed on worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N						145.00
						1.00		
						2.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N						146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N						147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N						148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N						149.00
						1.00		
						2.00		
						3.00		
						4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N			155.00
156.00	Subprovider - IPF	N	N	N	N			156.00
157.00	Subprovider - IRF	N	N	N	N			157.00
158.00	SUBPROVIDER							158.00
159.00	SNF	N	N	N	N			159.00
160.00	HOME HEALTH AGENCY	N	N	N	N			160.00
161.00	CMHC							161.00
161.10	CORF							161.10
161.20	OUTPATIENT PHYSICAL THERAPY							161.20
161.30	OUTPATIENT OCCUPATIONAL THERAPY							161.30
161.40	OUTPATIENT SPEECH PATHOLOGY							161.40
						1.00		
Multicampus								
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N						165.00
						1.00		
						2.00		
						3.00		
						4.00		
						5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5					0.00		166.00
						1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y						167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	483,205						168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00						169.00
						1.00		
						2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2013		12/31/2013				170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151323		Period: From 01/01/2013 To 12/31/2013		Worksheet S-2 Part II Date/Time Prepared: 5/27/2014 5:15 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date			V/I	
		1.00	2.00			3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type			Date	
		1.00	2.00			3.00	
Financial Data and Reports							
4.00	Column 1: were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	04/24/2013			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N			Legal Oper.		
		1.00			2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N					9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N			14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N			15.00
				Y/N			
				1.00			
PS&R Data							
		Description		Part A		Part B	
		0		Y/N	Date	Y/N	
				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)	N				N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y		05/01/2014		Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	Y				Y	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N				N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N				N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 151323

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

Worksheet S-2
Part II
Date/Time Prepared:
5/27/2014 5:15 pm

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	was the cost report prepared only using the provider's records? If yes, see instructions.	1.00 N	2.00	3.00 N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ERIC		NICKESON	41.00
42.00	Enter the employer/company name of the cost report preparer.	PARKVIEW HEALTH SYSTEM, INC.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(260) 373-8406		ERIC.NICKESON@PARKVIEW.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 151323

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

Worksheet S-2
Part II
Date/Time Prepared:
5/27/2014 5:15 pm

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	05/01/2014	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR, REIMBURSEMENT	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151323

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

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2014 5:15 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	66,960.00	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)		25	9,125	66,960.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,125	66,960.00	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
25.10 CMHC - CORF	99.10				0	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151323

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

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2014 5:15 pm

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)	878	206	2,636			1.00
2.00 HMO and other (see instructions)	568	147				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	273	0	273			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	271			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,151	206	3,180			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		131	590			13.00
14.00 Total (see instructions)	1,151	337	3,770	0.00	171.40	14.00
15.00 CAH visits	6,463	2,143	31,860			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
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
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	171.40	27.00
28.00 Observation Bed Days		29	594			28.00
29.00 Ambulance Trips	6,423					29.00
30.00 Employee discount days (see instruction)			59			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	1	115			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151323

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

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2014 5:15 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid workers	Title v	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	281	65	939	1.00
2.00 HMO and other (see instructions)				74			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	281	65	939		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
25.10 CMHC - CORF	0.00						25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00						25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00						25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00						25.40
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 WAGE RELATED COSTS

Provider CCN: 151323

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

Worksheet S-3
Part IV
Date/Time Prepared:
5/27/2014 5:15 pm

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 151323	Period: From 01/01/2013 To 12/31/2013	Worksheet S-10	Date/Time Prepared: 5/27/2014 5:15 pm
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.369406		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		690,360		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		227,555		5.00
6.00	Medicaid charges		6,879,490		6.00
7.00	Medicaid cost (line 1 times line 6)		2,541,325		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)		1,623,410		8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0		9.00
10.00	Stand-alone SCHIP charges		0		10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0		11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		27,297		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		110,319		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		40,753		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)		13,456		16.00
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		1,636,866		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	429,067	1,061,034	1,490,101	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	158,500	391,952	550,452	21.00
22.00	Partial payment by patients approved for charity care	400	36,699	37,099	22.00
23.00	Cost of charity care (line 21 minus line 22)	158,100	355,253	513,353	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)		3,300,000		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		248,958		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		3,051,042		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,127,073		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,640,426		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,277,292		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151323

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

Worksheet A

Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT		1,650,479	1,650,479	-396,302	1,254,177 1.00
1.01 00101	EMS WEST STATION		0	0	16,040	16,040 1.01
2.00 00200	CAP REL COSTS-MVBLE EQUIP		0	0	692,071	692,071 2.00
2.01 00201	EMS WEST STATION EQUIP.		0	0	27,304	27,304 2.01
3.00 00300	OTHER CAPITAL RELATED COSTS		0	0	0	0 3.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,216,009	2,770,244	3,986,253	0	3,986,253 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	6,365,250	2,232,871	8,598,121	-43,513	8,554,608 5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00 00700	OPERATION OF PLANT	244,442	637,388	881,830	-20,705	861,125 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	80,069	80,069	0	80,069 8.00
9.00 00900	HOUSEKEEPING	166,697	24,431	191,128	-34	191,094 9.00
10.00 01000	DIETARY	315,594	240,167	555,761	-286,242	269,519 10.00
11.00 01100	CAFETERIA	0	0	0	284,634	284,634 11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00 01300	NURSING ADMINISTRATION	238,854	398	239,252	0	239,252 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	23,841	-28,855	-5,014	-35	-5,049 14.00
15.00 01500	PHARMACY	405,192	590,350	995,542	-529,598	465,944 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	0 20.00
21.00 02100	I&R SRVCES-SALARY & FRINGES APPRVD	0	0	0	0	0 21.00
22.00 02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0	0	0	0 22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,531,670	200,705	1,732,375	-540,225	1,192,150 30.00
43.00 04300	NURSERY	0	0	0	151,762	151,762 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	594,100	352,381	946,481	-69,531	876,950 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	381,559	381,559 52.00
53.00 05300	ANESTHESIOLOGY	0	682,976	682,976	0	682,976 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	522,514	493,368	1,015,882	-51,693	964,189 54.00
60.00 06000	LABORATORY	0	714,368	714,368	-901	713,467 60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00 06500	RESPIRATORY THERAPY	292,375	29,237	321,612	-3,592	318,020 65.00
66.00 06600	PHYSICAL THERAPY	531,585	15,758	547,343	-229,256	318,087 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	124,682	124,682 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	76,632	76,632 68.00
69.00 06900	ELECTROCARDIOLOGY	0	7,046	7,046	0	7,046 69.00
71.00 07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	419,827	419,827	-138,469	281,358 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	137,864	137,864 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	531,901	531,901 73.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	7,049	125	7,174	788	7,962 90.00
90.01 09001	LIFEBRIDGE SENIOR CARE	5,530	25,658	31,188	0	31,188 90.01
91.00 09100	EMERGENCY	611,167	1,478,041	2,089,208	-31,609	2,057,599 91.00
92.00 09200	OBSERVATION BEDS	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	831,227	295,586	1,126,813	-1,512	1,125,301 95.00
99.10 09910	CORF	0	0	0	0	0 99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0 99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0 99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0 99.40
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	195,620	195,620	-193,343	2,277 113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	13,903,096	13,108,238	27,011,334	-111,323	26,900,011 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,468	7,468	0	7,468 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	1,825	1,825	-901	924 192.00
194.00 07950	OCCUPATIONAL HEALTH	0	-129,323	-129,323	129,323	0 194.00
194.01 07951	FOUNDATION	25,298	21,848	47,146	0	47,146 194.01
194.03 07952	COMMUNITY & VOLUNTEER SVCS	14,245	84,357	98,602	0	98,602 194.03
194.04 07954	ER PHYSICIAN	0	0	0	-17,099	-17,099 194.04
194.06 07953	SHIPSHAWANA RADIOLOGY AND LAB	0	0	0	0	0 194.06
200.00	TOTAL (SUM OF LINES 118-199)	13,942,639	13,094,413	27,037,052	0	27,037,052 200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151323

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

Worksheet A
Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	17,836	1,272,013	1.00
1.01	00101	EMS WEST STATION	0	16,040	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-2,525	689,546	2.00
2.01	00201	EMS WEST STATION EQUIP.	0	27,304	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-494,202	3,492,051	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,525,782	6,028,826	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-4,035	857,090	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	80,069	8.00
9.00	00900	HOUSEKEEPING	0	191,094	9.00
10.00	01000	DIETARY	0	269,519	10.00
11.00	01100	CAFETERIA	-174,194	110,440	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	239,252	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	-5,049	14.00
15.00	01500	PHARMACY	0	465,944	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	0	0	21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-663	1,191,487	30.00
43.00	04300	NURSERY	0	151,762	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-2,047	874,903	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	381,559	52.00
53.00	05300	ANESTHESIOLOGY	-594,547	88,429	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-265	963,924	54.00
60.00	06000	LABORATORY	-228	713,239	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	318,020	65.00
66.00	06600	PHYSICAL THERAPY	-32,968	285,119	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	124,682	67.00
68.00	06800	SPEECH PATHOLOGY	-9,718	66,914	68.00
69.00	06900	ELECTROCARDIOLOGY	-5,296	1,750	69.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	281,358	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	137,864	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-171,722	360,179	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	7,962	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	31,188	90.01
91.00	09100	EMERGENCY	-722,519	1,335,080	91.00
92.00	09200	OBSERVATION BEDS	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-300	1,125,001	95.00
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-2,277	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,725,452	22,174,559	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,468	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	924	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	194.00
194.01	07951	FOUNDATION	-499	46,647	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	98,602	194.03
194.04	07954	ER PHYSICIAN	0	-17,099	194.04
194.06	07953	SHIPSHEWANA RADIOLOGY AND LAB	0	0	194.06
200.00		TOTAL (SUM OF LINES 118-199)	-4,725,951	22,311,101	200.00

RECLASSIFICATIONS

Provider CCN: 151323

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

Worksheet A-6
Date/Time Prepared:
5/27/2014 5:15 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - REHAB THERAPY RECLASS						
1.00	OCCUPATIONAL THERAPY	67.00	131,382	4,088	1.00	
2.00	SPEECH PATHOLOGY	68.00	74,320	2,312	2.00	
	TOTALS		205,702	6,400		
B - OB RECLASS						
1.00	NURSERY	43.00	139,740	12,022	1.00	
2.00	DELIVERY ROOM & LABOR ROOM	52.00	351,333	30,226	2.00	
	TOTALS		491,073	42,248		
C - CLINIC DIETICIAN						
1.00	CLINIC	90.00	788	0	1.00	
	TOTALS		788	0		
F - CAFETERIA RECLASS						
1.00	CAFETERIA	11.00	166,331	118,303	1.00	
	TOTALS		166,331	118,303		
G - INSURANCE RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	33,084	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	11,332	2.00	
	TOTALS		0	44,416		
H - DRUGS CHARGED TO PATIENTS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	537,073	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
	TOTALS		0	537,073		
I - SALARY RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,681,270	1.00	
	TOTALS		0	3,681,270		
J - OCCUPATIONAL HEALTH RECLASS						
1.00	OCCUPATIONAL HEALTH	194.00	0	129,323	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
	TOTALS		0	129,323		
K - DEPRECIATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	593,554	1.00	
2.00	EMS WEST STATION	1.01	0	16,040	2.00	
3.00	EMS WEST STATION EQUIP.	2.01	0	26,082	3.00	
4.00	ADMINISTRATIVE & GENERAL	5.00	0	7,584	4.00	
	TOTALS		0	643,260		
L - BLDG & LEASE EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	20,531	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	87,185	2.00	
3.00	EMS WEST STATION EQUIP.	2.01	0	1,222	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	
	TOTALS		0	108,938		
M - INTEREST RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	193,343	1.00	
	TOTALS		0	193,343		
N - IMPLANTABLE MEDICAL SUPPLIES						
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	137,864	1.00	
	TOTALS		0	137,864		
500.00	Grand Total: Increases		863,894	5,642,438	500.00	

RECLASSIFICATIONS

Provider CCN: 151323

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

Worksheet A-6
Date/Time Prepared:
5/27/2014 5:15 pm

		Decreases					
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - REHAB THERAPY RECLASS							
1.00	PHYSICAL THERAPY	66.00	205,702	6,400	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		205,702	6,400			
B - OB RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	491,073	42,248	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		491,073	42,248			
C - CLINIC DIETICIAN							
1.00	DIETARY	10.00	788	0	0		1.00
	TOTALS		788	0			
F - CAFETERIA RECLASS							
1.00	DIETARY	10.00	166,331	118,303	0		1.00
	TOTALS		166,331	118,303			
G - INSURANCE RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	44,416	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	44,416			
H - DRUGS CHARGED TO PATIENTS							
1.00	PHARMACY	15.00	0	529,011	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	2,453	0		2.00
3.00	OPERATING ROOM	50.00	0	2,133	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,381	0		4.00
5.00	EMERGENCY	91.00	0	1,805	0		5.00
6.00	AMBULANCE SERVICES	95.00	0	290	0		6.00
	TOTALS		0	537,073			
I - SALARY RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	3,681,270	0	0		1.00
	TOTALS		3,681,270	0			
J - OCCUPATIONAL HEALTH RECLASS							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	50,181	0		1.00
2.00	LABORATORY	60.00	0	901	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	366	0		3.00
4.00	PHYSICAL THERAPY	66.00	0	15,693	0		4.00
5.00	OCCUPATIONAL THERAPY	67.00	0	10,788	0		5.00
6.00	MEDICAL SUPPLIES CHRGD TO PATIENTS	71.00	0	605	0		6.00
7.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,172	0		7.00
8.00	EMERGENCY	91.00	0	28,518	0		8.00
9.00	ER PHYSICIAN	194.04	0	17,099	0		9.00
	TOTALS		0	129,323			
K - DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	643,260	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
4.00		0.00	0	0	9		4.00
	TOTALS		0	643,260			
L - BLDG & LEASE EXPENSE							
1.00	OPERATION OF PLANT	7.00	0	20,400	10		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	131	10		2.00
3.00	AMBULANCE SERVICES	95.00	0	1,222	10		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	6,681	0		4.00
5.00	OPERATION OF PLANT	7.00	0	305	0		5.00
6.00	HOUSEKEEPING	9.00	0	34	0		6.00
7.00	DIETARY	10.00	0	820	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	35	0		8.00
9.00	PHARMACY	15.00	0	587	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	4,451	0		10.00
11.00	OPERATING ROOM	50.00	0	67,398	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	3,226	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	1,461	0		13.00
14.00	EMERGENCY	91.00	0	1,286	0		14.00
15.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	901	0		15.00
	TOTALS		0	108,938			
M - INTEREST RECLASS							
1.00	INTEREST EXPENSE	113.00	0	193,343	11		1.00
	TOTALS		0	193,343			
N - IMPLANTABLE MEDICAL SUPPLIES							
1.00	MEDICAL SUPPLIES CHRGD TO PATIENTS	71.00	0	137,864	0		1.00
	TOTALS		0	137,864			
500.00	Grand Total: Decreases		4,545,164	1,961,168			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151323

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

Worksheet A-7
Part I
Date/Time Prepared:
5/27/2014 5:15 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	265,000	0	0	0	1.00
2.00	Land Improvements	1,917,116	48,494	0	48,494	2.00
3.00	Buildings and Fixtures	13,245,217	0	0	0	3.00
4.00	Building Improvements	29,098	0	0	0	4.00
5.00	Fixed Equipment	7,627,345	7,991	0	7,991	5.00
6.00	Movable Equipment	6,996,251	306,578	0	306,578	6.00
7.00	HIT designated Assets	782,692	483,205	0	483,205	7.00
8.00	Subtotal (sum of lines 1-7)	30,862,719	846,268	0	846,268	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	30,862,719	846,268	0	846,268	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	265,000	0			1.00
2.00	Land Improvements	1,965,610	185,270			2.00
3.00	Buildings and Fixtures	13,245,217	46,306			3.00
4.00	Building Improvements	29,098	13,778			4.00
5.00	Fixed Equipment	7,635,336	506,894			5.00
6.00	Movable Equipment	7,162,294	2,774,136			6.00
7.00	HIT designated Assets	1,229,966	0			7.00
8.00	Subtotal (sum of lines 1-7)	31,532,521	3,526,384			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	31,532,521	3,526,384			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151323

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

Worksheet A-7
Part II
Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	1,640,914	0	0	0	9,565	1.00
1.01	EMS WEST STATION	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
2.01	EMS WEST STATION EQUIP.	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	1,640,914	0	0	0	9,565	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	1,650,479				1.00
1.01	EMS WEST STATION	0	0				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
2.01	EMS WEST STATION EQUIP.	0	0				2.01
3.00	Total (sum of lines 1-2)	0	1,650,479				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151323

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

Worksheet A-7
Part III
Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	22,819,454	0	22,819,454	0.760417	0	1.00
1.01	EMS WEST STATION	320,808	0	320,808	0.010690	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	7,018,884	293,428	6,725,456	0.224114	0	2.00
2.01	EMS WEST STATION EQUIP.	143,409	0	143,409	0.004779	0	2.01
3.00	Total (sum of lines 1-2)	30,302,555	293,428	30,009,127	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,015,594	20,531	1.00
1.01	EMS WEST STATION	0	0	0	16,040	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	591,029	87,185	2.00
2.01	EMS WEST STATION EQUIP.	0	0	0	26,082	1,222	2.01
3.00	Total (sum of lines 1-2)	0	0	0	1,648,745	108,938	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	193,239	33,084	9,565	0	1,272,013	1.00
1.01	EMS WEST STATION	0	0	0	0	16,040	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	11,332	0	0	689,546	2.00
2.01	EMS WEST STATION EQUIP.	0	0	0	0	27,304	2.01
3.00	Total (sum of lines 1-2)	193,239	44,416	9,565	0	2,004,903	3.00

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Ref.
				Cost Center	Line #	Wkst. A-7	
				1.00	2.00	3.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-104	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - EMS WEST STATION (chapter 2)		0	EMS WEST STATION	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - EMS WEST STATION EQUIP. (chapter 2)		0	EMS WEST STATION EQUIP.	2.01	0	2.01
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)	A	-4,035	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,456,010			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-2,367,528			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-174,194	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		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - EMS WEST STATION		0	EMS WEST STATION	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - EMS WEST STATION EQUIP.		0	EMS WEST STATION EQUIP.	2.01	0	27.01
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	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

Provider CCN: 151323

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

Worksheet A-8
Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center	Line #		
			1.00	2.00	3.00	
30.99 Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-155,881	ADMINISTRATIVE & GENERAL	5.00	0	32.00
33.00 TELEVISION SERVICES	A	-2,525	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.00
34.00 MISCELLANEOUS REVENUE	B	-5,086	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00 SPEECH THERAPY CONTRACTED	B	-9,718	SPEECH PATHOLOGY	68.00	0	35.00
36.00 NON-PATIENT EMS REVENUE	B	-300	AMBULANCE SERVICES	95.00	0	36.00
37.00		0		0.00	0	37.00
38.00 PHARMACY EMPLOYEE RX PURCHASES	B	-171,722	DRUGS CHARGED TO PATIENTS	73.00	0	38.00
39.00		0		0.00	0	39.00
40.00 SELF INSURANCE	A	-494,202	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
41.00 LOBBY % OF DUES & SUBSCRIPTIONS	A	-2,984	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00 EKG INTERPRETATION COSTS	A	-5,296	ELECTROCARDIOLOGY	69.00	0	42.00
43.00 MARKETING	A	-2,047	OPERATING ROOM	50.00	0	43.00
44.00 MARKETING	A	-440	PHYSICAL THERAPY	66.00	0	44.00
45.00 MARKETING	A	-499	FOUNDATION	194.01	0	45.00
46.00		0		0.00	0	46.00
47.00 ADD-BACK OF DEMOLISHED ASSET DEPREC	A	17,940	CAP REL COSTS-BLDG & FIXT	1.00	9	47.00
48.00 ADD-BACK OF DEMOLITION COSTS	A	4,125	ADMINISTRATIVE & GENERAL	5.00	0	48.00
49.00 NOT REALTED TO PATIENT CARE	A	-32,528	PHYSICAL THERAPY	66.00	0	49.00
49.01 RPS IMAGINE SERVICES	B	-265	RADIOLOGY-DIAGNOSTIC	54.00	0	49.01
49.02 MEDICAL DIRECTOR ADDITIONAL A/P	A	-663	ADULTS & PEDIATRICS	30.00	0	49.02
49.03 ON-CALL PROF TIME	A	-115,217	ANESTHESIOLOGY	53.00	0	49.03
49.04 GROSS-UP ANESTHESIA EXPENSE FOR A/R	A	254,161	ANESTHESIOLOGY	53.00	0	49.04
49.05 CHARITY CONTRIBUTIONS	A	-705	ADMINISTRATIVE & GENERAL	5.00	0	49.05
49.06 LABORATORY	B	-228	LABORATORY	60.00	0	49.06
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-4,725,951				50.00

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

Provider CCN: 151323

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

Worksheet A-8-1

Date/Time Prepared:
5/27/2014 5:15 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED					
HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	4,645,130	5,694,000 1.00
2.00	113.00	INTEREST EXPENSE	RELATED PARTY INTERET	0	2,277 2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY SUBSIDY ADJ.	0	1,316,381 3.00
4.00	0.00			0	0 4.00
4.01	0.00			0	0 4.01
4.02	0.00			0	0 4.02
4.03	0.00			0	0 4.03
4.04	0.00			0	0 4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.			4,645,130	7,012,658 5.00

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

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

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

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

6.00	B		0.00	PARKVIEW HEALTH SYSTEM, INC.	0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					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: 151323

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

Worksheet A-8-1
Date/Time Prepared:
5/27/2014 5:15 pm

	Net Adjustments (col. 4 minus col. 5)*	wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-1,048,870	0		1.00
2.00	-2,277	0		2.00
3.00	-1,316,381	0		3.00
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
5.00	-2,367,528			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	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151323

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

Worksheet A-8-2

Date/Time Prepared:
5/27/2014 5:15 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	53.00	ANESTHESIOLOGY	406,733	318,396	88,337	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	415,095	415,095	0	0	0	2.00
3.00	91.00	EMERGENCY	30,000	0	30,000	0	0	3.00
4.00	91.00	EMERGENCY	1,353,420	722,519	630,901	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	8,369	0	8,369	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			2,213,617	1,456,010	757,607			200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	53.00	ANESTHESIOLOGY	0	0	0	318,396		1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	415,095		2.00
3.00	91.00	EMERGENCY	0	0	0	0		3.00
4.00	91.00	EMERGENCY	0	0	0	722,519		4.00
5.00	30.00	ADULTS & PEDIATRICS	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	1,456,010		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151323

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

Worksheet B
Part I
Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
		BLDG & FIXT	EMS WEST STATION	MVBLE EQUIP	EMS WEST STATION EQUIP.	
		1.00	1.01	2.00	2.01	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT	1,272,013	1,272,013				1.00
1.01 00101 EMS WEST STATION	16,040	0	16,040			1.01
2.00 00200 CAP REL COSTS-MVBLE EQUIP	689,546			689,546		2.00
2.01 00201 EMS WEST STATION EQUIP.	27,304			0	27,304	2.01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	3,492,051	0	0	0	0	4.00
5.00 00500 ADMINISTRATIVE & GENERAL	6,028,826	231,165	0	125,312	0	5.00
6.00 00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 00700 OPERATION OF PLANT	857,090	72,536	0	39,321	0	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	80,069	4,147	0	2,248	0	8.00
9.00 00900 HOUSEKEEPING	191,094	13,573	0	7,358	0	9.00
10.00 01000 DIETARY	269,519	51,111	0	27,707	0	10.00
11.00 01100 CAFETERIA	110,440	0	0	0	0	11.00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 01300 NURSING ADMINISTRATION	239,252	0	0	0	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	-5,049	29,211	0	15,835	0	14.00
15.00 01500 PHARMACY	465,944	22,261	0	12,067	0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	13,163	0	7,136	0	16.00
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00 02000 NURSING SCHOOL	0	0	0	0	0	20.00
21.00 02100 I&R SRVCES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00 02200 I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	1,191,487	287,426	0	155,809	0	30.00
43.00 04300 NURSERY	151,762	4,328	0	2,346	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	874,903	163,825	0	88,808	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	381,559	20,458	0	11,090	0	52.00
53.00 05300 ANESTHESIOLOGY	88,429	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	963,924	81,191	0	44,013	0	54.00
60.00 06000 LABORATORY	713,239	32,391	0	17,559	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00 06500 RESPIRATORY THERAPY	318,020	17,687	0	9,588	0	65.00
66.00 06600 PHYSICAL THERAPY	285,119	54,291	0	29,431	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	124,682	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	66,914	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	1,750	1,524	0	826	0	69.00
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	281,358	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	137,864	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	360,179	0	0	0	0	73.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99 07699 LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	7,962	0	0	0	0	90.00
90.01 09001 LIFEBRIDGE SENIOR CARE	31,188	0	0	0	0	90.01
91.00 09100 EMERGENCY	1,335,080	113,451	0	61,501	0	91.00
92.00 09200 OBSERVATION BEDS						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	1,125,001	0	16,040	0	27,304	95.00
99.10 09910 CORF	0	0	0	0	0	99.10
99.20 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	22,174,559	1,213,739	16,040	657,955	27,304	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,468	3,655	0	1,982	0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	924	54,619	0	29,609	0	192.00
194.00 07950 OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01 07951 FOUNDATION	46,647	0	0	0	0	194.01
194.03 07952 COMMUNITY & VOLUNTEER SVCS	98,602	0	0	0	0	194.03
194.04 07954 ER PHYSICIAN	-17,099	0	0	0	0	194.04
194.06 07953 SHIPSHAWANA RADIOLOGY AND LAB	0	0	0	0	0	194.06
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00

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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151323

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

Worksheet B
Part I
Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS				
		BLDG & FIXT	EMS WEST STATION	MVBLE EQUIP	EMS WEST STATION EQUIP.	
	0	1.00	1.01	2.00	2.01	
202.00 TOTAL (sum lines 118-201)	22,311,101	1,272,013	16,040	689,546	27,304	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151323

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

Worksheet B
Part I
Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT 4.00	Subtotal 4A	ADMINISTRATIVE & GENERAL 5.00	MAINTENANCE & REPAIRS 6.00	OPERATION OF PLANT 7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	EMS WEST STATION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	EMS WEST STATION EQUIP.						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,492,051					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,036,178	7,421,481	7,421,481			5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0		6.00
7.00	00700	OPERATION OF PLANT	94,369	1,063,316	529,384	0	1,592,700	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	86,464	43,047	0	6,822	8.00
9.00	00900	HOUSEKEEPING	64,355	276,380	137,599	0	22,325	9.00
10.00	01000	DIETARY	57,320	405,657	201,961	0	84,069	10.00
11.00	01100	CAFETERIA	64,214	174,654	86,953	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	92,212	331,464	165,023	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,204	49,201	24,495	0	48,047	14.00
15.00	01500	PHARMACY	156,428	656,700	326,945	0	36,615	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,299	10,106	0	21,651	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	401,733	2,036,455	1,013,882	0	472,758	30.00
43.00	04300	NURSERY	53,948	212,384	105,738	0	7,118	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	229,358	1,356,894	675,545	0	269,463	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	135,636	548,743	273,198	0	33,649	52.00
53.00	05300	ANESTHESIOLOGY	0	88,429	44,025	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	201,722	1,290,850	642,664	0	133,545	54.00
60.00	06000	LABORATORY	0	763,189	379,962	0	53,278	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	112,874	458,169	228,104	0	29,093	65.00
66.00	06600	PHYSICAL THERAPY	125,810	494,651	246,267	0	89,300	66.00
67.00	06700	OCCUPATIONAL THERAPY	50,721	175,403	87,326	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	28,692	95,606	47,598	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,100	2,041	0	2,508	69.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	281,358	140,077	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	137,864	68,637	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	360,179	179,319	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,026	10,988	5,470	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	2,135	33,323	16,590	0	0	90.01
91.00	09100	EMERGENCY	235,947	1,745,979	869,255	0	186,607	91.00
92.00	09200	OBSERVATION BEDS	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	320,903	1,489,248	741,438	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,476,785	22,069,428	7,292,649	0	1,496,848	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,105	6,524	0	6,013	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	85,152	42,394	0	89,839	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	9,767	56,414	28,086	0	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	5,499	104,101	51,828	0	0	194.03
194.04	07954	ER PHYSICIAN	0	-17,099	0	0	0	194.04
194.06	07953	SHIPSHEWANA RADIOLOGY AND LAB	0	0	0	0	0	194.06
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)	3,492,051	22,311,101	7,421,481	0	1,592,700	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151323

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

Worksheet B
Part I
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Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	
		8.00	9.00	10.00	11.00	12.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800	136,333					8.00
9.00	00900	0	436,304				9.00
10.00	01000	913	23,459	716,059			10.00
11.00	01100	0	0	0	261,607		11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	0	0	0	0	0	13.00
14.00	01400	0	13,407	0	0	0	14.00
15.00	01500	0	10,217	0	13,224	0	15.00
16.00	01600	0	6,042	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	44,843	131,922	716,059	54,757	0	30.00
43.00	04300	1,636	1,986	0	5,706	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	22,631	75,193	0	29,640	0	50.00
52.00	05200	7,539	9,390	0	15,424	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	12,624	37,265	0	25,264	0	54.00
60.00	06000	0	14,867	0	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	1,840	8,118	0	14,530	0	65.00
66.00	06600	5,835	24,919	0	13,877	0	66.00
67.00	06700	2,549	0	0	5,464	0	67.00
68.00	06800	1,445	0	0	2,273	0	68.00
69.00	06900	0	700	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	338	0	90.00
90.01	09001	0	0	0	0	0	90.01
91.00	09100	26,571	52,072	0	28,987	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	4,431	0	0	52,123	0	95.00
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		132,857	409,557	716,059	261,607	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	1,678	0	0	0	190.00
192.00	19200	3,476	25,069	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.03	07952	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.06	07953	0	0	0	0	0	194.06
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		136,333	436,304	716,059	261,607	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151323

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

Worksheet B
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Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
12.00	01200						12.00
13.00	01300	496,487					13.00
14.00	01400	0	135,150				14.00
15.00	01500	0	3,853	1,047,554			15.00
16.00	01600	0	0	0	58,098		16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	202,113	9,967	150	9,034	0	30.00
43.00	04300	21,098	815	17	2,277	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	109,371	23,748	1,532	1,464	0	50.00
52.00	05200	56,923	3,759	92	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	3,664	55,624	11,033	0	54.00
60.00	06000	0	0	0	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	0	1,879	449	0	0	65.00
66.00	06600	0	911	1,727	10,690	0	66.00
67.00	06700	0	398	754	2,940	0	67.00
68.00	06800	0	225	426	192	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	39,917	0	0	0	71.00
72.00	07200	0	19,486	0	0	0	72.00
73.00	07300	0	0	968,981	0	0	73.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	4	0	0	0	90.00
90.01	09001	0	718	0	0	0	90.01
91.00	09100	106,982	7,952	3,598	20,468	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	17,632	14,204	0	0	95.00
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		496,487	134,928	1,047,554	58,098	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	72	0	0	0	190.00
192.00	19200	0	50	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	74	0	0	0	194.01
194.03	07952	0	26	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.06	07953	0	0	0	0	0	194.06
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		496,487	135,150	1,047,554	58,098	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151323

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

Worksheet B
Part I
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Cost Center Description	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS		PARAMED ED PRGM	
			SRVCES-SALARY & FRINGES	SRVCES-OTHER PRGM COSTS		
			19.00	20.00		
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	EMS WEST STATION					1.01
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
2.01 00201	EMS WEST STATION EQUIP.					2.01
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
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					16.00
17.00 01700	SOCIAL SERVICE					17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0				19.00
20.00 02000	NURSING SCHOOL	0	0			20.00
21.00 02100	I&R SRVCES-SALARY & FRINGES APPRVD	0	0	0		21.00
22.00 02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
43.00 04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	0	50.00
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
60.00 06000	LABORATORY	0	0	0	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
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 CHRGD 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
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 09001	LIFEBRIDGE SENIOR CARE	0	0	0	0	90.01
91.00 09100	EMERGENCY	0	0	0	0	91.00
92.00 09200	OBSERVATION BEDS					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
99.10 09910	CORF	0	0	0	0	99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	OCCUPATIONAL HEALTH	0	0	0	0	194.00
194.01 07951	FOUNDATION	0	0	0	0	194.01
194.03 07952	COMMUNITY & VOLUNTEER SVCS	0	0	0	0	194.03
194.04 07954	ER PHYSICIAN	0	0	0	0	194.04
194.06 07953	SHIPSHEWANA RADIOLOGY AND LAB	0	0	0	0	194.06
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151323

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

Worksheet B
Part I
Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	EMS WEST STATION				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	EMS WEST STATION EQUIP.				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
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				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00	02000	NURSING SCHOOL				20.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,691,940	0	4,691,940	30.00
43.00	04300	NURSERY	358,775	0	358,775	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,565,481	0	2,565,481	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	948,717	0	948,717	52.00
53.00	05300	ANESTHESIOLOGY	132,454	0	132,454	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,212,533	0	2,212,533	54.00
60.00	06000	LABORATORY	1,211,296	0	1,211,296	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	742,182	0	742,182	65.00
66.00	06600	PHYSICAL THERAPY	888,177	0	888,177	66.00
67.00	06700	OCCUPATIONAL THERAPY	274,834	0	274,834	67.00
68.00	06800	SPEECH PATHOLOGY	147,765	0	147,765	68.00
69.00	06900	ELECTROCARDIOLOGY	9,349	0	9,349	69.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	461,352	0	461,352	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	225,987	0	225,987	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,508,479	0	1,508,479	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	16,800	0	16,800	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	50,631	0	50,631	90.01
91.00	09100	EMERGENCY	3,048,471	0	3,048,471	91.00
92.00	09200	OBSERVATION BEDS		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,319,076	0	2,319,076	95.00
99.10	09910	CORF	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,814,299	0	21,814,299	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	27,392	0	27,392	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	245,980	0	245,980	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	194.00
194.01	07951	FOUNDATION	84,574	0	84,574	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	155,955	0	155,955	194.03
194.04	07954	ER PHYSICIAN	-17,099	0	-17,099	194.04
194.06	07953	SHIPSHAWANA RADIOLOGY AND LAB	0	0	0	194.06
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	22,311,101	0	22,311,101	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151323

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

Worksheet B
Part II
Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
			BLDG & FIXT	EMS WEST STATION	MVBLE EQUIP	EMS WEST STATION EQUIP.	
		0	1.00	1.01	2.00	2.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	EMS WEST STATION					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	EMS WEST STATION EQUIP.					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	877,710	231,165	0	125,312	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	72,536	0	39,321	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,147	0	2,248	8.00
9.00	00900	HOUSEKEEPING	0	13,573	0	7,358	9.00
10.00	01000	DIETARY	0	51,111	0	27,707	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	29,211	0	15,835	14.00
15.00	01500	PHARMACY	0	22,261	0	12,067	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,163	0	7,136	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	287,426	0	155,809	30.00
43.00	04300	NURSERY	0	4,328	0	2,346	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	163,825	0	88,808	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	20,458	0	11,090	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	81,191	0	44,013	54.00
60.00	06000	LABORATORY	0	32,391	0	17,559	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	17,687	0	9,588	65.00
66.00	06600	PHYSICAL THERAPY	0	54,291	0	29,431	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	1,524	0	826	69.00
71.00	07100	MEDICAL SUPPLIES CHRGD 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
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	113,451	0	61,501	91.00
92.00	09200	OBSERVATION BEDS	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	16,040	0	95.00
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	877,710	1,213,739	16,040	657,955	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,655	0	1,982	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	54,619	0	29,609	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	0	0	0	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	194.04
194.06	07953	SHIPSHEWANA RADIOLOGY AND LAB	0	0	0	0	194.06
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	877,710	1,272,013	16,040	689,546	202.00

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ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151323

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

Worksheet B
Part II
Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
		2A	4.00	5.00	6.00	7.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	EMS WEST STATION					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	EMS WEST STATION EQUIP.					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,234,187	0	1,234,187		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	111,857	0	88,036	0	199,893
8.00	00800	LAUNDRY & LINEN SERVICE	6,395	0	7,159	0	856
9.00	00900	HOUSEKEEPING	20,931	0	22,883	0	2,802
10.00	01000	DIETARY	78,818	0	33,586	0	10,551
11.00	01100	CAFETERIA	0	0	14,460	0	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	0	27,443	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	45,046	0	4,074	0	6,030
15.00	01500	PHARMACY	34,328	0	54,371	0	4,595
16.00	01600	MEDICAL RECORDS & LIBRARY	20,299	0	1,681	0	2,717
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	443,235	0	168,604	0	59,335
43.00	04300	NURSERY	6,674	0	17,584	0	893
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	252,633	0	112,343	0	33,819
52.00	05200	DELIVERY ROOM & LABOR ROOM	31,548	0	45,433	0	4,223
53.00	05300	ANESTHESIOLOGY	0	0	7,321	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	125,204	0	106,875	0	16,761
60.00	06000	LABORATORY	49,950	0	63,187	0	6,687
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	27,275	0	37,934	0	3,651
66.00	06600	PHYSICAL THERAPY	83,722	0	40,954	0	11,208
67.00	06700	OCCUPATIONAL THERAPY	0	0	14,522	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	7,916	0	0
69.00	06900	ELECTROCARDIOLOGY	2,350	0	339	0	315
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	23,295	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	11,414	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	29,821	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	910	0	0
90.01	09001	LIFEBRIDGE SENIOR CARE	0	0	2,759	0	0
91.00	09100	EMERGENCY	174,952	0	144,557	0	23,420
92.00	09200	OBSERVATION BEDS	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	43,344	0	123,301	0	0
99.10	09910	CORF	0	0	0	0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,792,748	0	1,212,762	0	187,863
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,637	0	1,085	0	755
192.00	19200	PHYSICIANS' PRIVATE OFFICES	84,228	0	7,050	0	11,275
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0
194.01	07951	FOUNDATION	0	0	4,671	0	0
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	0	8,619	0	0
194.04	07954	ER PHYSICIAN	0	0	0	0	0
194.06	07953	SHIPSHEWANA RADIOLOGY AND LAB	0	0	0	0	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	2,882,613	0	1,234,187	0	199,893

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151323

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

Worksheet B
Part II
Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	
		8.00	9.00	10.00	11.00	12.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800	14,410					8.00
9.00	00900	0	46,616				9.00
10.00	01000	97	2,506	125,558			10.00
11.00	01100	0	0	0	14,460		11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	0	0	0	0	0	13.00
14.00	01400	0	1,432	0	0	0	14.00
15.00	01500	0	1,092	0	731	0	15.00
16.00	01600	0	646	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	4,739	14,096	125,558	3,027	0	30.00
43.00	04300	173	212	0	315	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,392	8,034	0	1,638	0	50.00
52.00	05200	797	1,003	0	853	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	1,334	3,982	0	1,396	0	54.00
60.00	06000	0	1,588	0	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	195	867	0	803	0	65.00
66.00	06600	617	2,662	0	767	0	66.00
67.00	06700	269	0	0	302	0	67.00
68.00	06800	153	0	0	126	0	68.00
69.00	06900	0	75	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	19	0	90.00
90.01	09001	0	0	0	0	0	90.01
91.00	09100	2,809	5,564	0	1,602	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	468	0	0	2,881	0	95.00
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		14,043	43,759	125,558	14,460	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	179	0	0	0	190.00
192.00	19200	367	2,678	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.03	07952	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.06	07953	0	0	0	0	0	194.06
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		14,410	46,616	125,558	14,460	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151323

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

Worksheet B
Part II
Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
12.00	01200						12.00
13.00	01300	27,443					13.00
14.00	01400	0	54,544				14.00
15.00	01500	0	1,555	96,672			15.00
16.00	01600	0	0	0	25,343		16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	11,173	4,022	14	3,941	0	30.00
43.00	04300	1,166	329	2	993	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	6,045	9,584	141	639	0	50.00
52.00	05200	3,146	1,517	9	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	1,479	5,133	4,813	0	54.00
60.00	06000	0	0	0	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	0	758	41	0	0	65.00
66.00	06600	0	367	159	4,663	0	66.00
67.00	06700	0	161	70	1,282	0	67.00
68.00	06800	0	91	39	84	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	16,111	0	0	0	71.00
72.00	07200	0	7,864	0	0	0	72.00
73.00	07300	0	0	89,421	0	0	73.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	1	0	0	0	90.00
90.01	09001	0	290	0	0	0	90.01
91.00	09100	5,913	3,209	332	8,928	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	7,116	1,311	0	0	95.00
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		27,443	54,454	96,672	25,343	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	29	0	0	0	190.00
192.00	19200	0	20	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	30	0	0	0	194.01
194.03	07952	0	11	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.06	07953	0	0	0	0	0	194.06
200.00							200.00
201.00		0	2,038	0	0	0	201.00
202.00		27,443	56,582	96,672	25,343	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151323

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

Worksheet B
Part II
Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description	INTERNS & RESIDENTS					PARAMED ED PRGM
	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	SRVCES-SALARY & FRINGES	SRVCES-OTHER PRGM COSTS		
	19.00	20.00	21.00	22.00	23.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	EMS WEST STATION					1.01
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
2.01 00201	EMS WEST STATION EQUIP.					2.01
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
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					16.00
17.00 01700	SOCIAL SERVICE					17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0				19.00
20.00 02000	NURSING SCHOOL		0			20.00
21.00 02100	I&R SRVCES-SALARY & FRINGES APPRVD			0		21.00
22.00 02200	I&R SRVCES-OTHER PRGM COSTS APPRVD				0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)					0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS					30.00
43.00 04300	NURSERY					43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM					50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM					52.00
53.00 05300	ANESTHESIOLOGY					53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC					54.00
60.00 06000	LABORATORY					60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65.00 06500	RESPIRATORY THERAPY					65.00
66.00 06600	PHYSICAL THERAPY					66.00
67.00 06700	OCCUPATIONAL THERAPY					67.00
68.00 06800	SPEECH PATHOLOGY					68.00
69.00 06900	ELECTROCARDIOLOGY					69.00
71.00 07100	MEDICAL SUPPLIES CHRGD TO PATIENTS					71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT					72.00
73.00 07300	DRUGS CHARGED TO PATIENTS					73.00
76.97 07697	CARDIAC REHABILITATION					76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY					76.98
76.99 07699	LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC					90.00
90.01 09001	LIFEBRIDGE SENIOR CARE					90.01
91.00 09100	EMERGENCY					91.00
92.00 09200	OBSERVATION BEDS					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES					95.00
99.10 09910	CORF					99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY					99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY					99.40
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	0	0	0 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN					190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES					192.00
194.00 07950	OCCUPATIONAL HEALTH					194.00
194.01 07951	FOUNDATION					194.01
194.03 07952	COMMUNITY & VOLUNTEER SVCS					194.03
194.04 07954	ER PHYSICIAN					194.04
194.06 07953	SHIPSHEWANA RADIOLOGY AND LAB					194.06
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)	0	0	0	0	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151323

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

Worksheet B
Part II
Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	EMS WEST STATION				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	EMS WEST STATION EQUIP.				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
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				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00	02000	NURSING SCHOOL				20.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	837,744	0	837,744	30.00
43.00	04300	NURSERY	28,341	0	28,341	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	427,268	0	427,268	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	88,529	0	88,529	52.00
53.00	05300	ANESTHESIOLOGY	7,321	0	7,321	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	266,977	0	266,977	54.00
60.00	06000	LABORATORY	121,412	0	121,412	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	71,524	0	71,524	65.00
66.00	06600	PHYSICAL THERAPY	145,119	0	145,119	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,606	0	16,606	67.00
68.00	06800	SPEECH PATHOLOGY	8,409	0	8,409	68.00
69.00	06900	ELECTROCARDIOLOGY	3,079	0	3,079	69.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	39,406	0	39,406	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,278	0	19,278	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	119,242	0	119,242	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	930	0	930	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	3,049	0	3,049	90.01
91.00	09100	EMERGENCY	371,286	0	371,286	91.00
92.00	09200	OBSERVATION BEDS		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	178,421	0	178,421	95.00
99.10	09910	CORF	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,753,941	0	2,753,941	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,685	0	7,685	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	105,618	0	105,618	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	194.00
194.01	07951	FOUNDATION	4,701	0	4,701	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	8,630	0	8,630	194.03
194.04	07954	ER PHYSICIAN	0	0	0	194.04
194.06	07953	SHIPSHAWANA RADIOLOGY AND LAB	0	0	0	194.06
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	2,038	0	2,038	201.00
202.00		TOTAL (sum lines 118-201)	2,882,613	0	2,882,613	202.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151323

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

Worksheet B-1

Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description		CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
		BLDG & FIXT (SQUARE FEET)	EMS WEST STATION (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMS WEST STATION EQUIP. (SQUARE FEET)		
		1.00	1.01	2.00	2.01		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	77,598				1.00
1.01	00101	EMS WEST STATION	0	9,760			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			77,598		2.00
2.01	00201	EMS WEST STATION EQUIP.			0	9,760	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,102	0	14,102	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	4,425	0	4,425	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	253	0	253	0	8.00
9.00	00900	HOUSEKEEPING	828	0	828	0	9.00
10.00	01000	DIETARY	3,118	0	3,118	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,782	0	1,782	0	14.00
15.00	01500	PHARMACY	1,358	0	1,358	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	803	0	803	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	17,534	0	17,534	0	30.00
43.00	04300	NURSERY	264	0	264	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,994	0	9,994	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,248	0	1,248	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,953	0	4,953	0	54.00
60.00	06000	LABORATORY	1,976	0	1,976	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,079	0	1,079	0	65.00
66.00	06600	PHYSICAL THERAPY	3,312	0	3,312	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	93	0	93	0	69.00
71.00	07100	MEDICAL SUPPLIES CHRGD 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
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	0	0	0	90.01
91.00	09100	EMERGENCY	6,921	0	6,921	0	91.00
92.00	09200	OBSERVATION BEDS	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	9,760	0	9,760	95.00
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	74,043	9,760	74,043	9,760	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	223	0	223	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,332	0	3,332	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	0	0	0	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	194.04
194.06	07953	SHIPSHAWANA RADIOLOGY AND LAB	0	0	0	0	194.06
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151323

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

Worksheet B-1

Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description		CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
		BLDG & FIXT (SQUARE FEET)	EMS WEST STATION (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMS WEST STATION EQUIP. (SQUARE FEET)		
		1.00	1.01	2.00	2.01		
202.00	Cost to be allocated (per wkst. B, Part I)	1,272,013	16,040	689,546	27,304	3,492,051	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	16.392343	1.643443	8.886131	2.797541	0.386060	203.00
204.00	Cost to be allocated (per wkst. B, Part II)					0	204.00
205.00	Unit cost multiplier (wkst. B, Part II)					0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151323

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

Worksheet B-1
Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		5A	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	-7,421,481	14,906,719				6.00
7.00	00700				59,071		7.00
8.00	00800				253	10,000	8.00
9.00	00900				828		9.00
10.00	01000				3,118	67	10.00
11.00	01100						11.00
12.00	01200						12.00
13.00	01300						13.00
14.00	01400				1,782		14.00
15.00	01500				1,358		15.00
16.00	01600				803		16.00
17.00	01700						17.00
19.00	01900						19.00
20.00	02000						20.00
21.00	02100						21.00
22.00	02200						22.00
23.00	02300						23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000				17,534	3,289	30.00
43.00	04300				264	120	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000				9,994	1,660	50.00
52.00	05200				1,248	553	52.00
53.00	05300						53.00
54.00	05400				4,953	926	54.00
60.00	06000				1,976		60.00
62.30	06250						62.30
65.00	06500				1,079	135	65.00
66.00	06600				3,312	428	66.00
67.00	06700					187	67.00
68.00	06800					106	68.00
69.00	06900				93		69.00
71.00	07100						71.00
72.00	07200						72.00
73.00	07300						73.00
76.97	07697						76.97
76.98	07698						76.98
76.99	07699						76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000						90.00
90.01	09001						90.01
91.00	09100				6,921	1,949	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500					325	95.00
99.10	09910						99.10
99.20	09920						99.20
99.30	09930						99.30
99.40	09940						99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		-7,421,481	14,647,947		55,516	9,745	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000				223		190.00
192.00	19200				3,332	255	192.00
194.00	07950						194.00
194.01	07951						194.01
194.03	07952						194.03
194.04	07954	17,099					194.04
194.06	07953						194.06
200.00							200.00
201.00							201.00
202.00							202.00
203.00							203.00
			7,421,481		1,592,700	136,333	
			0.497861	0.000000	26.962469	13.633300	

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151323

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

Worksheet B-1

Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		5A	5.00	6.00	7.00	8.00	
204.00	Cost to be allocated (per wkst. B, Part II)		1,234,187	0	199,893	14,410	204.00
205.00	Unit cost multiplier (wkst. B, Part II)		0.082794	0.000000	3.383945	1.441000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151323

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

Worksheet B-1

Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description			HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	
			9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	EMS WEST STATION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	EMS WEST STATION EQUIP.						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	57,990					9.00
10.00	01000	DIETARY	3,118	20,156				10.00
11.00	01100	CAFETERIA	0	0	10,821			11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	116,369	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,782	0	0	0	0	14.00
15.00	01500	PHARMACY	1,358	0	547	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	803	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,534	20,156	2,265	0	47,372	30.00
43.00	04300	NURSERY	264	0	236	0	4,945	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,994	0	1,226	0	25,635	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,248	0	638	0	13,342	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,953	0	1,045	0	0	54.00
60.00	06000	LABORATORY	1,976	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,079	0	601	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,312	0	574	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	226	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	94	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	93	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHRGD 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
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	14	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	6,921	0	1,199	0	25,075	91.00
92.00	09200	OBSERVATION BEDS						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	2,156	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	54,435	20,156	10,821	0	116,369	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	223	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,332	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	0	0	0	0	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	0	194.04
194.06	07953	SHIPSHAWANA RADIOLOGY AND LAB	0	0	0	0	0	194.06
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)	436,304	716,059	261,607	0	496,487	202.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151323

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

Worksheet B-1

Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description		HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
		9.00	10.00	11.00	12.00	13.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	7.523780	35.525848	24.175862	0.000000	4.266488	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	46,616	125,558	14,460	0	27,443	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.803863	6.229311	1.336291	0.000000	0.235827	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151323

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

Worksheet B-1
Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description			CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			14.00	15.00	16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	EMS WEST STATION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	EMS WEST STATION EQUIP.						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	956,170					14.00
15.00	01500	PHARMACY	27,263	181,943				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	10,000			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0		20.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	0	0	0	0		21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0	0	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	70,514	26	1,555	0		30.00
43.00	04300	NURSERY	5,766	3	392	0		43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	168,013	266	252	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26,597	16	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,920	9,661	1,899	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	13,294	78	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	6,442	300	1,840	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,814	131	506	2,814	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,592	74	33	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	282,402	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	137,864	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	168,296	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	26	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	5,080	0	0	0	0	90.01
91.00	09100	EMERGENCY	56,258	625	3,523	0	0	91.00
92.00	09200	OBSERVATION BEDS						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	124,744	2,467	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	954,589	181,943	10,000	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	512	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	356	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	527	0	0	0	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	186	0	0	0	0	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	0	194.04
194.06	07953	SHIPSHAWANA RADIOLOGY AND LAB	0	0	0	0	0	194.06
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)	135,150	1,047,554	58,098	0	0	202.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151323

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

Worksheet B-1

Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		14.00	15.00	16.00	17.00	19.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	0.141345	5.757594	5.809800	0.000000	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	56,582	96,672	25,343	0	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.057044	0.531331	2.534300	0.000000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151323

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

Worksheet B-1
Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMED ED PRGM (ASSIGNED TIME)		
		SRVCES-SALARY & FRINGES (ASSIGNED TIME)	SRVCES-OTHER PRGM COSTS (ASSIGNED TIME)			
		20.00	21.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	EMS WEST STATION					1.01
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
2.01 00201	EMS WEST STATION EQUIP.					2.01
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
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					16.00
17.00 01700	SOCIAL SERVICE					17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00 02000	NURSING SCHOOL	0				20.00
21.00 02100	I&R SRVCES-SALARY & FRINGES APPRVD		0			21.00
22.00 02200	I&R SRVCES-OTHER PRGM COSTS APPRVD			0		22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)				0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
43.00 04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	0	50.00
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
60.00 06000	LABORATORY	0	0	0	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
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 CHRGD 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
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 09001	LIFEBRIDGE SENIOR CARE	0	0	0	0	90.01
91.00 09100	EMERGENCY	0	0	0	0	91.00
92.00 09200	OBSERVATION BEDS					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
99.10 09910	CORF	0	0	0	0	99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	OCCUPATIONAL HEALTH	0	0	0	0	194.00
194.01 07951	FOUNDATION	0	0	0	0	194.01
194.03 07952	COMMUNITY & VOLUNTEER SVCS	0	0	0	0	194.03
194.04 07954	ER PHYSICIAN	0	0	0	0	194.04
194.06 07953	SHIPSHEWANA RADIOLOGY AND LAB	0	0	0	0	194.06
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151323

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

Worksheet B-1
Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description	NURSING SCHOOL (ASSIGNED TIME) 20.00	INTERNS & RESIDENTS		PARAMED ED PRGM (ASSIGNED TIME) 23.00	
		SRVCES-SALARY & FRINGES (ASSIGNED TIME) 21.00	SRVCES-OTHER PRGM COSTS (ASSIGNED TIME) 22.00		
		202.00	Cost to be allocated (per wkst. B, Part I)		
203.00	Unit cost multiplier (wkst. B, Part I)	0.000000	0.000000	0.000000	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	0	0	0	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	0.000000	0.000000	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151323

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

Worksheet C
Part I
Date/Time Prepared:
5/27/2014 5:15 pm

		Title XVIII		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		4,691,940	0	0	30.00
43.00	04300 NURSERY		358,775	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		2,565,481	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		948,717	0	0	52.00
53.00	05300 ANESTHESIOLOGY		132,454	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		2,212,533	0	0	54.00
60.00	06000 LABORATORY		1,211,296	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	742,182	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	888,177	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	274,834	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	147,765	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY		9,349	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS		461,352	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		225,987	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		1,508,479	0	0	73.00
76.97	07697 CARDIAC REHABILITATION		0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY		0	0	0	76.98
76.99	07699 LITHOTRIPSY		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		16,800	0	0	90.00
90.01	09001 LIFEBRIDGE SENIOR CARE		50,631	0	0	90.01
91.00	09100 EMERGENCY		3,048,471	0	0	91.00
92.00	09200 OBSERVATION BEDS		789,943	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		2,319,076	0	0	95.00
99.10	09910 CORF		0	0	0	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY		0	0	0	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY		0	0	0	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY		0	0	0	99.40
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		22,604,242	0	0	200.00
201.00	Less Observation Beds		789,943			201.00
202.00	Total (see instructions)		21,814,299	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151323

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

Worksheet C
Part I
Date/Time Prepared:
5/27/2014 5:15 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	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,996,266		3,996,266		30.00
43.00	04300	NURSERY	573,689		573,689		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,822,667	5,900,595	8,723,262	0.294097	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,398,785	43,703	1,442,488	0.657695	52.00
53.00	05300	ANESTHESIOLOGY	242,465	562,827	805,292	0.164479	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	956,955	15,275,484	16,232,439	0.136303	54.00
60.00	06000	LABORATORY	959,933	3,213,529	4,173,462	0.290238	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	559,518	1,438,277	1,997,795	0.371501	65.00
66.00	06600	PHYSICAL THERAPY	212,685	1,252,764	1,465,449	0.606078	66.00
67.00	06700	OCCUPATIONAL THERAPY	216,139	324,055	540,194	0.508769	67.00
68.00	06800	SPEECH PATHOLOGY	21,967	66,106	88,073	1.677756	68.00
69.00	06900	ELECTROCARDIOLOGY	104,142	149,974	254,116	0.036790	69.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	482,554	1,136,235	1,618,789	0.284998	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	711,075	108,234	819,309	0.275826	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,181,217	2,937,569	5,118,786	0.294695	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	8,181	8,181	2.053539	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	1,220	1,220	41.500820	90.01
91.00	09100	EMERGENCY	268,026	7,137,736	7,405,762	0.411635	91.00
92.00	09200	OBSERVATION BEDS	0	635,159	635,159	1.243693	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	3,152,565	3,152,565	0.735616	95.00
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	15,708,083	43,344,213	59,052,296		200.00
201.00		Less observation Beds					201.00
202.00		Total (see instructions)	15,708,083	43,344,213	59,052,296		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151323

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

Worksheet C
Part I
Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
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 CHRGD 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
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699 LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
90.01	09001 LIFEBRIDGE SENIOR CARE	0.000000			90.01
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
99.10	09910 CORF				99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY				99.40
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151323

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

Worksheet C
Part I
Date/Time Prepared:
5/27/2014 5:15 pm

		Title XIX		Hospital		PPS		
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		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,691,940		4,691,940	0	4,691,940	30.00
43.00	04300	NURSERY	358,775		358,775	0	358,775	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,565,481		2,565,481	0	2,565,481	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	948,717		948,717	0	948,717	52.00
53.00	05300	ANESTHESIOLOGY	132,454		132,454	0	132,454	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,212,533		2,212,533	0	2,212,533	54.00
60.00	06000	LABORATORY	1,211,296		1,211,296	0	1,211,296	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	742,182	0	742,182	0	742,182	65.00
66.00	06600	PHYSICAL THERAPY	888,177	0	888,177	0	888,177	66.00
67.00	06700	OCCUPATIONAL THERAPY	274,834	0	274,834	0	274,834	67.00
68.00	06800	SPEECH PATHOLOGY	147,765	0	147,765	0	147,765	68.00
69.00	06900	ELECTROCARDIOLOGY	9,349		9,349	0	9,349	69.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	461,352		461,352	0	461,352	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	225,987		225,987	0	225,987	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,508,479		1,508,479	0	1,508,479	73.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	16,800		16,800	0	16,800	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	50,631		50,631	0	50,631	90.01
91.00	09100	EMERGENCY	3,048,471		3,048,471	0	3,048,471	91.00
92.00	09200	OBSERVATION BEDS	789,943		789,943	0	789,943	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	2,319,076		2,319,076	0	2,319,076	95.00
99.10	09910	CORF	0		0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	22,604,242	0	22,604,242	0	22,604,242	200.00
201.00		Less Observation Beds	789,943		789,943		789,943	201.00
202.00		Total (see instructions)	21,814,299	0	21,814,299	0	21,814,299	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151323

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

Worksheet C
Part I
Date/Time Prepared:
5/27/2014 5:15 pm

		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					
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,996,266		3,996,266		30.00
43.00	04300	NURSERY	573,689		573,689		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,822,667	5,900,595	8,723,262	0.294097	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,398,785	43,703	1,442,488	0.657695	52.00
53.00	05300	ANESTHESIOLOGY	242,465	562,827	805,292	0.164479	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	956,955	15,275,484	16,232,439	0.136303	54.00
60.00	06000	LABORATORY	959,933	3,213,529	4,173,462	0.290238	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	559,518	1,438,277	1,997,795	0.371501	65.00
66.00	06600	PHYSICAL THERAPY	212,685	1,252,764	1,465,449	0.606078	66.00
67.00	06700	OCCUPATIONAL THERAPY	216,139	324,055	540,194	0.508769	67.00
68.00	06800	SPEECH PATHOLOGY	21,967	66,106	88,073	1.677756	68.00
69.00	06900	ELECTROCARDIOLOGY	104,142	149,974	254,116	0.036790	69.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	482,554	1,136,235	1,618,789	0.284998	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	711,075	108,234	819,309	0.275826	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,181,217	2,937,569	5,118,786	0.294695	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	8,181	8,181	2.053539	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	1,220	1,220	41.500820	90.01
91.00	09100	EMERGENCY	268,026	7,137,736	7,405,762	0.411635	91.00
92.00	09200	OBSERVATION BEDS	0	635,159	635,159	1.243693	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	3,152,565	3,152,565	0.735616	95.00
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	15,708,083	43,344,213	59,052,296		200.00
201.00		Less observation Beds					201.00
202.00		Total (see instructions)	15,708,083	43,344,213	59,052,296		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151323

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

Worksheet C
Part I
Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.294097			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.657695			52.00
53.00	05300 ANESTHESIOLOGY	0.164479			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.136303			54.00
60.00	06000 LABORATORY	0.290238			60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500 RESPIRATORY THERAPY	0.371501			65.00
66.00	06600 PHYSICAL THERAPY	0.606078			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.508769			67.00
68.00	06800 SPEECH PATHOLOGY	1.677756			68.00
69.00	06900 ELECTROCARDIOLOGY	0.036790			69.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0.284998			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.275826			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.294695			73.00
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699 LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	2.053539			90.00
90.01	09001 LIFEBRIDGE SENIOR CARE	41.500820			90.01
91.00	09100 EMERGENCY	0.411635			91.00
92.00	09200 OBSERVATION BEDS	1.243693			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.735616			95.00
99.10	09910 CORF				99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY				99.40
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less observation Beds				201.00
202.00	Total (see instructions)				202.00

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

Provider CCN: 151323

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

Worksheet C
Part II
Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description			Title XIX			Hospital		PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, 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		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	2,565,481	427,268	2,138,213	0	0	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	948,717	88,529	860,188	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	132,454	7,321	125,133	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,212,533	266,977	1,945,556	0	0	54.00	
60.00	06000	LABORATORY	1,211,296	121,412	1,089,884	0	0	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	742,182	71,524	670,658	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	888,177	145,119	743,058	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	274,834	16,606	258,228	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	147,765	8,409	139,356	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	9,349	3,079	6,270	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	461,352	39,406	421,946	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	225,987	19,278	206,709	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1,508,479	119,242	1,389,237	0	0	73.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	16,800	930	15,870	0	0	90.00	
90.01	09001	LIFEBRIDGE SENIOR CARE	50,631	3,049	47,582	0	0	90.01	
91.00	09100	EMERGENCY	3,048,471	371,286	2,677,185	0	0	91.00	
92.00	09200	OBSERVATION BEDS	789,943	0	789,943	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	2,319,076	178,421	2,140,655	0	0	95.00	
99.10	09910	CORF	0	0	0	0	0	99.10	
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20	
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30	
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (sum of lines 50 thru 199)	17,553,527	1,887,856	15,665,671	0	0	200.00	
201.00		Less Observation Beds	789,943	0	789,943	0	0	201.00	
202.00		Total (line 200 minus line 201)	16,763,584	1,887,856	14,875,728	0	0	202.00	

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		Provider CCN: 151323	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part II Date/Time Prepared: 5/27/2014 5:15 pm
		Title XIX	Hospital	PPS

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)	
		6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	2,565,481	8,723,262	0.294097	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	948,717	1,442,488	0.657695	52.00
53.00	05300 ANESTHESIOLOGY	132,454	805,292	0.164479	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,212,533	16,232,439	0.136303	54.00
60.00	06000 LABORATORY	1,211,296	4,173,462	0.290238	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	62.30
65.00	06500 RESPIRATORY THERAPY	742,182	1,997,795	0.371501	65.00
66.00	06600 PHYSICAL THERAPY	888,177	1,465,449	0.606078	66.00
67.00	06700 OCCUPATIONAL THERAPY	274,834	540,194	0.508769	67.00
68.00	06800 SPEECH PATHOLOGY	147,765	88,073	1.677756	68.00
69.00	06900 ELECTROCARDIOLOGY	9,349	254,116	0.036790	69.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	461,352	1,618,789	0.284998	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	225,987	819,309	0.275826	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,508,479	5,118,786	0.294695	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	76.98
76.99	07699 LITHOTRIPSY	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	16,800	8,181	2.053539	90.00
90.01	09001 LIFEBRIDGE SENIOR CARE	50,631	1,220	41.500820	90.01
91.00	09100 EMERGENCY	3,048,471	7,405,762	0.411635	91.00
92.00	09200 OBSERVATION BEDS	789,943	635,159	1.243693	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	2,319,076	3,152,565	0.735616	95.00
99.10	09910 CORF	0	0	0.000000	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0.000000	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0.000000	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0.000000	99.40
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (sum of lines 50 thru 199)	17,553,527	54,482,341		200.00
201.00	Less Observation Beds	789,943	0		201.00
202.00	Total (line 200 minus line 201)	16,763,584	54,482,341		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151323	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/27/2014 5:15 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	427,268	8,723,262	0.048980	228,056	11,170	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	88,529	1,442,488	0.061372	1,382	85	52.00
53.00	05300 ANESTHESIOLOGY	7,321	805,292	0.009091	26,731	243	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	266,977	16,232,439	0.016447	245,969	4,045	54.00
60.00	06000 LABORATORY	121,412	4,173,462	0.029091	210,479	6,123	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	71,524	1,997,795	0.035801	177,803	6,366	65.00
66.00	06600 PHYSICAL THERAPY	145,119	1,465,449	0.099027	44,538	4,410	66.00
67.00	06700 OCCUPATIONAL THERAPY	16,606	540,194	0.030741	42,457	1,305	67.00
68.00	06800 SPEECH PATHOLOGY	8,409	88,073	0.095478	7,304	697	68.00
69.00	06900 ELECTROCARDIOLOGY	3,079	254,116	0.012117	54,351	659	69.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	39,406	1,618,789	0.024343	114,520	2,788	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	19,278	819,309	0.023530	292,111	6,873	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	119,242	5,118,786	0.023295	542,667	12,641	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	930	8,181	0.113678	0	0	90.00
90.01	09001 LIFE BRIDGE SENIOR CARE	3,049	1,220	2.499180	0	0	90.01
91.00	09100 EMERGENCY	371,286	7,405,762	0.050135	12,553	629	91.00
92.00	09200 OBSERVATION BEDS	0	635,159	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	1,709,435	51,329,776		2,000,921	58,034	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151323

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

Worksheet D
Part IV
Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description		Title XVIII				Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)			
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151323

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

Worksheet D
Part IV
Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Cost		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	8,723,262	0.000000	0.000000	228,056	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,442,488	0.000000	0.000000	1,382	52.00
53.00	05300	ANESTHESIOLOGY	0	805,292	0.000000	0.000000	26,731	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,232,439	0.000000	0.000000	245,969	54.00
60.00	06000	LABORATORY	0	4,173,462	0.000000	0.000000	210,479	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,997,795	0.000000	0.000000	177,803	65.00
66.00	06600	PHYSICAL THERAPY	0	1,465,449	0.000000	0.000000	44,538	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	540,194	0.000000	0.000000	42,457	67.00
68.00	06800	SPEECH PATHOLOGY	0	88,073	0.000000	0.000000	7,304	68.00
69.00	06900	ELECTROCARDIOLOGY	0	254,116	0.000000	0.000000	54,351	69.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	1,618,789	0.000000	0.000000	114,520	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	819,309	0.000000	0.000000	292,111	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,118,786	0.000000	0.000000	542,667	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	8,181	0.000000	0.000000	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	1,220	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	7,405,762	0.000000	0.000000	12,553	91.00
92.00	09200	OBSERVATION BEDS	0	635,159	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	51,329,776			2,000,921	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151323

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

Worksheet D
Part IV
Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	Cost
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
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
60.00	06000 LABORATORY	0	0	0		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
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 CHRGD 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
76.97	07697 CARDIAC REHABILITATION	0	0	0		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
76.99	07699 LITHOTRIPSY	0	0	0		76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
90.01	09001 LIFE BRIDGE SENIOR CARE	0	0	0		90.01
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151323

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

Worksheet D
Part V
Date/Time Prepared:
5/27/2014 5:15 pm

		Title XVIII		Hospital		Cost		
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.294097	0	1,051,234	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.657695	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.164479	0	106,258	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136303	0	3,573,723	0	0	54.00
60.00	06000	LABORATORY	0.290238	0	929,783	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.371501	0	388,568	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.606078	0	405,613	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.508769	0	63,356	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.677756	0	14,761	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.036790	0	51,037	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0.284998	0	123,674	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.275826	0	44,683	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.294695	0	936,702	2,430	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2.053539	0	1,188	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	41.500820	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.411635	0	1,736,622	0	0	91.00
92.00	09200	OBSERVATION BEDS	1.243693	0	320,996	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.735616	0	0	0	0	95.00
200.00		Subtotal (see instructions)		0	9,748,198	2,430	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	9,748,198	2,430	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151323	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 5:15 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Costs		Hospital	Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	309,165	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	17,477	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	487,109	0	54.00
60.00	06000 LABORATORY	269,858	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	144,353	0	65.00
66.00	06600 PHYSICAL THERAPY	245,833	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	32,234	0	67.00
68.00	06800 SPEECH PATHOLOGY	24,765	0	68.00
69.00	06900 ELECTROCARDIOLOGY	1,878	0	69.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	35,247	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	12,325	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	276,041	716	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699 LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	2,440	0	90.00
90.01	09001 LIFEBRIDGE SENIOR CARE	0	0	90.01
91.00	09100 EMERGENCY	714,854	0	91.00
92.00	09200 OBSERVATION BEDS	399,220	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0		95.00
200.00	Subtotal (see instructions)	2,972,799	716	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	2,972,799	716	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151323

Period:

Worksheet D

Component CCN: 152323

From 01/01/2013
To 12/31/2013

Part V
Date/Time Prepared:
5/27/2014 5:15 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 Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.294097	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.657695	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.164479	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.136303	0	0	0	54.00
60.00	06000 LABORATORY	0.290238	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.371501	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.606078	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.508769	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	1.677756	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.036790	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0.284998	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.275826	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.294695	0	0	0	73.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	2.053539	0	0	0	90.00
90.01	09001 LIFE BRIDGE SENIOR CARE	41.500820	0	0	0	90.01
91.00	09100 EMERGENCY	0.411635	0	0	0	91.00
92.00	09200 OBSERVATION BEDS	1.243693	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0.735616	0	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: 151323 Component CCN: 15Z323	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 5:15 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
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
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
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 CHRGD 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
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
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: 151323		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part I Date/Time Prepared: 5/27/2014 5:15 pm	
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	PPS Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	837,744	70,790	766,954	3,230	237.45	30.00
43.00	NURSERY	28,341		28,341	590	48.04	43.00
200.00	Total (lines 30-199)	866,085		795,295	3,820		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	206	48,915				
43.00	NURSERY	131	6,293				
200.00	Total (lines 30-199)	337	55,208				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151323

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

Worksheet D
Part II
Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	427,268	8,723,262	0.048980	211,805	10,374	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	88,529	1,442,488	0.061372	197,876	12,144	52.00
53.00	05300 ANESTHESIOLOGY	7,321	805,292	0.009091	61,267	557	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	266,977	16,232,439	0.016447	49,606	816	54.00
60.00	06000 LABORATORY	121,412	4,173,462	0.029091	81,441	2,369	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	71,524	1,997,795	0.035801	38,230	1,369	65.00
66.00	06600 PHYSICAL THERAPY	145,119	1,465,449	0.099027	7,028	696	66.00
67.00	06700 OCCUPATIONAL THERAPY	16,606	540,194	0.030741	4,101	126	67.00
68.00	06800 SPEECH PATHOLOGY	8,409	88,073	0.095478	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	3,079	254,116	0.012117	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	39,406	1,618,789	0.024343	46,977	1,144	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	19,278	819,309	0.023530	23,056	543	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	119,242	5,118,786	0.023295	147,644	3,439	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	930	8,181	0.113678	0	0	90.00
90.01	09001 LIFE BRIDGE SENIOR CARE	3,049	1,220	2.499180	0	0	90.01
91.00	09100 EMERGENCY	371,286	7,405,762	0.050135	33,777	1,693	91.00
92.00	09200 OBSERVATION BEDS	154,063	635,159	0.242558	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	1,863,498	51,329,776		902,808	35,270	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 151323		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part III Date/Time Prepared: 5/27/2014 5:15 pm	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	PPS Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
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		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,230	0.00	206	0		30.00
43.00	04300	NURSERY	590	0.00	131	0		43.00
200.00		Total (lines 30-199)	3,820		337	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151323

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

Worksheet D
Part IV
Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description		Title XIX				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00	
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	
60.00	06000	LABORATORY	0	0	0	0	0	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30	
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 CHRGD 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	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	90.00	
90.01	09001	LIFEBRIDGE SENIOR CARE	0	0	0	0	0	90.01	
91.00	09100	EMERGENCY	0	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS	0	0	0	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS									
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: 151323

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

Worksheet D
Part IV
Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description		Title XIX			Hospital		PPS	
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	8,723,262	0.000000	0.000000	211,805	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,442,488	0.000000	0.000000	197,876	52.00
53.00	05300	ANESTHESIOLOGY	0	805,292	0.000000	0.000000	61,267	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,232,439	0.000000	0.000000	49,606	54.00
60.00	06000	LABORATORY	0	4,173,462	0.000000	0.000000	81,441	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,997,795	0.000000	0.000000	38,230	65.00
66.00	06600	PHYSICAL THERAPY	0	1,465,449	0.000000	0.000000	7,028	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	540,194	0.000000	0.000000	4,101	67.00
68.00	06800	SPEECH PATHOLOGY	0	88,073	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	254,116	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	1,618,789	0.000000	0.000000	46,977	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	819,309	0.000000	0.000000	23,056	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,118,786	0.000000	0.000000	147,644	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	8,181	0.000000	0.000000	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	1,220	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	7,405,762	0.000000	0.000000	33,777	91.00
92.00	09200	OBSERVATION BEDS	0	635,159	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	51,329,776			902,808	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151323

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

Worksheet D
Part IV
Date/Time Prepared:
5/27/2014 5:15 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		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
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
60.00	06000 LABORATORY	0	0	0		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
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 CHRGD 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
76.97	07697 CARDIAC REHABILITATION	0	0	0		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
76.99	07699 LITHOTRIPSY	0	0	0		76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
90.01	09001 LIFE BRIDGE SENIOR CARE	0	0	0		90.01
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151323	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 5:15 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			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.294097	0	306,208	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.657695	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.164479	0	35,128	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136303	0	1,033,951	0	0	54.00
60.00	06000	LABORATORY	0.290238	0	207,338	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.371501	0	52,500	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.606078	0	56,626	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.508769	0	26,322	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.677756	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.036790	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0.284998	0	82,229	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.275826	0	357	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.294695	0	148,684	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2.053539	0	12,135	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	41.500820	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.411635	0	767,292	0	0	91.00
92.00	09200	OBSERVATION BEDS	1.243693	0	31,581	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.735616	0	239,001	0	0	95.00
200.00		Subtotal (see instructions)		0	2,999,352	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	2,999,352	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151323	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 5:15 pm
		Title XIX	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	90,055	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	5,778	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	140,931	0	54.00
60.00	06000 LABORATORY	60,177	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	19,504	0	65.00
66.00	06600 PHYSICAL THERAPY	34,320	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	13,392	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 CHRGED TO PATIENTS	23,435	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	98	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	43,816	0	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699 LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	24,920	0	90.00
90.01	09001 LIFEBRIDGE SENIOR CARE	0	0	90.01
91.00	09100 EMERGENCY	315,844	0	91.00
92.00	09200 OBSERVATION BEDS	39,277	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	175,813		95.00
200.00	Subtotal (see instructions)	987,360	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	987,360	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151323	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/27/2014 5:15 pm
Cost Center Description		Title XVIII	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,774	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,230	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,636	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		273	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		271	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)		878	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)		273	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		123.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		123.32	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,691,940	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)		33,420	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)		396,475	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,295,465	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,295,465	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,329.87	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,167,626	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)		1,167,626	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151323		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/27/2014 5:15 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	Cost Program Cost (col. 3 x col. 4)	
42.00 NURSERY (title V & XIX only)		1.00	2.00	3.00	4.00	5.00	0
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					574,193	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,741,819	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0
52.00	Total Program excludable cost (sum of lines 50 and 51)						0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						0
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)						0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0
58.00	Bonus payment (see instructions)						0
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
62.00	Relief payment (see instructions)						0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					363,055	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)					363,055	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					594	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,329.87	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					789,943	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151323		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/27/2014 5:15 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151323	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/27/2014 5:15 pm
Cost Center Description		Title XIX	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,774	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,230	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,636	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		273	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		271	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)		206	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)		590	15.00
16.00	Nursery days (title V or XIX only)		131	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		123.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		123.32	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,691,940	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)		33,420	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)		396,475	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,295,465	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,295,465	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,329.87	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		273,953	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)		273,953	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151323		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/27/2014 5:15 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	PPS Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	358,775	590	608.09	131	79,660	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					330,617	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					684,230	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					55,208	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					35,270	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					90,478	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					593,752	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					594	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,329.87	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					789,943	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151323		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/27/2014 5:15 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	837,744	4,295,465	0.195030	789,943	154,063	90.00
91.00	Nursing School cost	0	4,295,465	0.000000	789,943	0	91.00
92.00	Allied health cost	0	4,295,465	0.000000	789,943	0	92.00
93.00	All other Medical Education	0	4,295,465	0.000000	789,943	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151323	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/27/2014 5:15 pm	
Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	Cost Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,080,406	30.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.294097	228,056	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.657695	1,382	52.00
53.00	05300	ANESTHESIOLOGY	0.164479	26,731	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136303	245,969	54.00
60.00	06000	LABORATORY	0.290238	210,479	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.371501	177,803	65.00
66.00	06600	PHYSICAL THERAPY	0.606078	44,538	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.508769	42,457	67.00
68.00	06800	SPEECH PATHOLOGY	1.677756	7,304	68.00
69.00	06900	ELECTROCARDIOLOGY	0.036790	54,351	69.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0.284998	114,520	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.275826	292,111	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.294695	542,667	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	2.053539	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	41.500820	0	90.01
91.00	09100	EMERGENCY	0.411635	12,553	91.00
92.00	09200	OBSERVATION BEDS	1.243693	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		2,000,921	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)		2,000,921	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151323

Period:

Worksheet D-3

Component CCN: 152323

From 01/01/2013
To 12/31/2013

Date/Time Prepared:
5/27/2014 5:15 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	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		160,071		30.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.294097	2,642	777	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.657695	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.164479	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.136303	21,907	2,986	54.00
60.00	06000 LABORATORY	0.290238	28,576	8,294	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.371501	14,897	5,534	65.00
66.00	06600 PHYSICAL THERAPY	0.606078	66,947	40,575	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.508769	70,244	35,738	67.00
68.00	06800 SPEECH PATHOLOGY	1.677756	220	369	68.00
69.00	06900 ELECTROCARDIOLOGY	0.036790	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0.284998	8,488	2,419	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.275826	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.294695	91,728	27,032	73.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	2.053539	0	0	90.00
90.01	09001 LIFE BRIDGE SENIOR CARE	41.500820	0	0	90.01
91.00	09100 EMERGENCY	0.411635	1,157	476	91.00
92.00	09200 OBSERVATION BEDS	1.243693	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		306,806	124,200	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)		306,806		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151323	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/27/2014 5:15 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		146,842	30.00
43.00	04300	NURSERY		148,344	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.294097	211,805	62,291 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.657695	197,876	130,142 52.00
53.00	05300	ANESTHESIOLOGY	0.164479	61,267	10,077 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136303	49,606	6,761 54.00
60.00	06000	LABORATORY	0.290238	81,441	23,637 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0.371501	38,230	14,202 65.00
66.00	06600	PHYSICAL THERAPY	0.606078	7,028	4,260 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.508769	4,101	2,086 67.00
68.00	06800	SPEECH PATHOLOGY	1.677756	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.036790	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0.284998	46,977	13,388 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.275826	23,056	6,359 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.294695	147,644	43,510 73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0 76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0 76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	2.053539	0	0 90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	41.500820	0	0 90.01
91.00	09100	EMERGENCY	0.411635	33,777	13,904 91.00
92.00	09200	OBSERVATION BEDS	1.243693	0	0 92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			
200.00		Total (sum of lines 50-94 and 96-98)		902,808	330,617 200.00
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)		902,808	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151323	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/27/2014 5:15 pm
		Title XVIII	Hospital	Cost
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,973,515	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		2,973,515	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		3,003,250	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		25,378	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,763,315	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)		1,214,557	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)		1,214,557	30.00
31.00	Primary payer payments		1,502	31.00
32.00	Subtotal (line 30 minus line 31)		1,213,055	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		263,427	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		231,816	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		205,275	36.00
37.00	Subtotal (see instructions)		1,444,871	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)		1,444,871	40.00
40.01	Sequestration adjustment (see instructions)		21,818	40.01
41.00	Interim payments		1,413,726	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		9,327	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151323

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

Worksheet E-1
Part I
Date/Time Prepared:
5/27/2014 5:15 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		1,415,889		1,619,326	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	07/15/2013	87,700		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0	07/15/2013	205,600	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)		87,700		-205,600	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,503,589		1,413,726	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		26,342		9,327	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,529,931		1,423,053	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: 151323

Period:

Worksheet E-1

Component CCN: 152323

From 01/01/2013
To 12/31/2013

Part I
Date/Time Prepared:
5/27/2014 5:15 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		408,064		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		408,064		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		77,027		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		485,091		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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 151323	Period: From 01/01/2013 To 12/31/2013	Worksheet E-1 Part II Date/Time Prepared: 5/27/2014 5:15 pm
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from wkst S-3, Part I column 15 line 14			939 1.00
2.00	Medicare days from wkst S-3, Part I, column 6 sum of lines 1, 8-12			878 2.00
3.00	Medicare HMO days from wkst S-3, Part I, column 6. line 2			568 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			2,636 4.00
5.00	Total hospital charges from wkst C, Part I, column 8 line 200			59,052,296 5.00
6.00	Total hospital charity care charges from wkst S-10, column 3 line 20			1,490,101 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			483,205 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			368,637 8.00
9.00	Sequestration adjustment amount (see instructions)			7,373 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			361,264 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
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)			361,264 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151323

Period:

Worksheet E-2

Component CCN: 152323

From 01/01/2013
To 12/31/2013

Date/Time Prepared:
5/27/2014 5:15 pm

		Title XVIII		Swing Beds - SNF		Cost	
		Part A	Part B				
		1.00	2.00				
COMPUTATION OF NET COST OF COVERED SERVICES							
1.00	Inpatient routine services - swing bed-SNF (see instructions)	366,686	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)	125,442	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	273	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)	492,128	0				8.00
9.00	Primary payer payments (see instructions)	0	0				9.00
10.00	Subtotal (line 8 minus line 9)	492,128	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)	492,128	0				12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	888	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)	491,240	0				15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0				16.00
17.00	Allowable bad debts (see instructions)	1,981	0				17.00
17.01	Adjusted reimbursable bad debts (see instructions)	1,288	0				17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0				18.00
19.00	Total (see instructions)	492,528	0				19.00
19.01	Sequestration adjustment (see instructions)	7,437	0				19.01
20.00	Interim payments	408,064	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	77,027	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: 151323	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part V Date/Time Prepared: 5/27/2014 5:15 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHS)				
1.00	Inpatient services			1,741,819 1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 thru 3)			1,741,819 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1,759,237 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			1,759,237 19.00
20.00	Deductibles (exclude professional component)			221,408 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			1,537,829 22.00
23.00	Coinsurance			296 23.00
24.00	Subtotal (line 22 minus line 23)			1,537,533 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			18,016 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			15,854 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			4,736 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1,553,387 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (line 28, plus or minus lines 29)			1,553,387 30.00
30.01	Sequestration adjustment (see instructions)			23,456 30.01
31.00	Interim payments			1,503,589 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			26,342 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 34.00

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

Provider CCN: 151323

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

Worksheet G

Date/Time Prepared:
5/27/2014 5:15 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	4,601	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,863,656	0	0	0	4.00
5.00	Other receivable	-10,370	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	288,520	0	0	0	7.00
8.00	Prepaid expenses	131,112	0	0	0	8.00
9.00	Other current assets	-1,322,940	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)	2,954,579	0	0	0	11.00
FIXED ASSETS						
12.00	Land	265,000	0	0	0	12.00
13.00	Land improvements	1,965,610	0	0	0	13.00
14.00	Accumulated depreciation	-752,585	0	0	0	14.00
15.00	Buildings	13,245,217	0	0	0	15.00
16.00	Accumulated depreciation	-2,124,675	0	0	0	16.00
17.00	Leasehold improvements	29,098	0	0	0	17.00
18.00	Accumulated depreciation	-22,715	0	0	0	18.00
19.00	Fixed equipment	7,635,336	0	0	0	19.00
20.00	Accumulated depreciation	-3,106,571	0	0	0	20.00
21.00	Automobiles and trucks	42,445	0	0	0	21.00
22.00	Accumulated depreciation	-39,675	0	0	0	22.00
23.00	Major movable equipment	7,119,848	0	0	0	23.00
24.00	Accumulated depreciation	-4,981,525	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	19,274,808	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	5,012,312	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,012,312	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	27,241,699	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	351,852	0	0	0	37.00
38.00	Salaries, wages, and fees payable	520,290	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	735,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	-919,394	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	687,748	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	142,549	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	28,922,800	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	29,065,349	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	29,753,097	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-2,511,398				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-2,511,398	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	27,241,699	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151323

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

Worksheet G-1

Date/Time Prepared:
5/27/2014 5:15 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		-2,278,858		0		1.00
2.00	Net income (loss) (from wkst. G-3, line 29)		-297,123				2.00
3.00	Total (sum of line 1 and line 2)		-2,575,981		0		3.00
4.00	Additions	64,583		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)		64,583		0		10.00
11.00	Subtotal (line 3 plus line 10)		-2,511,398		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)		-2,511,398		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		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: 151323

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/27/2014 5:15 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	6,089,282		6,089,282	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)	6,089,282		6,089,282	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,089,282		6,089,282	17.00
18.00	Ancillary services	9,554,771	33,145,579	42,700,350	18.00
19.00	Outpatient services	0	8,178,419	8,178,419	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	3,157,604	3,157,604	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NON-REIMBURSEABLE COST CENTERS	118,866	3,401,035	3,519,901	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	15,762,919	47,882,637	63,645,556	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		27,037,052		29.00
30.00	BAD DEBT	3,299,839			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)		3,299,839		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)		30,336,891		43.00

STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 151323	Period: From 01/01/2013 To 12/31/2013	Worksheet G-3 Date/Time Prepared: 5/27/2014 5:15 pm
			1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)		63,645,556	1.00
2.00	Less contractual allowances and discounts on patients' accounts		34,728,577	2.00
3.00	Net patient revenues (line 1 minus line 2)		28,916,979	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)		30,336,891	4.00
5.00	Net income from service to patients (line 3 minus line 4)		-1,419,912	5.00
OTHER INCOME				
6.00	Contributions, donations, bequests, etc		88,798	6.00
7.00	Income from investments		-1,717	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		174,194	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		170,099	17.00
18.00	Revenue from sale of medical records and abstracts		0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)		0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen		11,958	20.00
21.00	Rental of vending machines		0	21.00
22.00	Rental of hospital space		32,219	22.00
23.00	Governmental appropriations		0	23.00
24.00	GAIN ON DISPOSAL OF ASSETS		-5,793	24.00
24.01	COUNTY REIMBURSEMENT OF AMBULANCE SV		349,000	24.01
24.02	MISCELLANEOUS		304,031	24.02
25.00	Total other income (sum of lines 6-24)		1,122,789	25.00
26.00	Total (line 5 plus line 25)		-297,123	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)		-297,123	29.00