

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

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

Provider CCN: 151333

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

Worksheet S Parts I-III Date/Time Prepared: 5/29/2014 3:30 pm

**PART I - COST REPORT STATUS**

Provider use only

1.  Electronically filed cost report

2.  Manually submitted cost report

3.  If this is an amended report enter the number of times the provider resubmitted this cost report

4.  Medicare Utilization. Enter "F" for full or "L" for low.

Date: 5/29/2014 Time: 3:30 pm

Contractor use only

5.  Cost Report Status

(1) As Submitted

(2) Settled without Audit

(3) Settled with Audit

(4) Reopened

(5) Amended

6. Date Received:

7. Contractor No.

8.  Initial Report for this Provider CCN

9.  Final Report for this Provider CCN

10. NPR Date:

11. Contractor's Vendor Code: 4

12.  If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**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 PUTNAM COUNTY HOSPITAL ( 151333 ) for the cost reporting period beginning 01/01/2013 and ending 12/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

**Encryption Information**

ECR: Date: 5/29/2014 Time: 3:30 pm

iu:KS1ceep5xIXwvwG02JmHhG4o60

q2GE30xEhfAZydg:naRj2D5XA9z49C

H0Tj0MpGm50eQBca

PI: Date: 5/29/2014 Time: 3:30 pm

7b1In.IuZvt1amTapap8v081xmz8z0

1qdKv0vvVo4ceJokjJf1PEARiyUj2n

Ersb0RinVj0DA1BX

(Signed) \_\_\_\_\_

Officer or Administrator of Provider(s)

*CFO*

Title \_\_\_\_\_

Date *5/30/14*

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	316,109	-256,246	118,363	10,278	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	53,003	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
10.00 RURAL HEALTH CLINIC I	0	0	0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0		0	11.00
200.00 Total	0	369,112	-256,246	118,363	10,278	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: 151333		Period: From 01/01/2013 To 12/31/2013		Worksheet S-2 Part I Date/Time Prepared: 5/29/2014 3:29 pm						
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 1542 SOUTH BLOOMINGTON ST		PO Box:						1.00			
2.00	City: GREENCASTLE		State: IN		Zip Code: 46135-		County: PUTNAM		2.00			
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
				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		PUTNAM COUNTY HOSPITAL		151333	99915	1	12/31/2005	N	0	0	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF		PUTNAM COUNTY HOSPITAL		152333	99915		12/31/2005	N	0	N	7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
17.10	Hospital-Based (CORF) I											17.10
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:	To:				
							1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2013	12/31/2013		20.00		
21.00	Type of Control (see instructions)						9		21.00			
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N		22.00			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)								22.01			
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						0		23.00			
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
				1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.						0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.						0	0	0	0	0	25.00
							Urban/Rural S	Date of Geogr				
							1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						2				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						2				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0				35.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151333	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/29/2014 3:29 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					39.00
		V 1.00	XVIII 2.00	XIX 3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06
		Program Name 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

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	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
	1.00	2.00	3.00	4.00		
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.		0.00	0.00	61.20	
				1.00		
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)			0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)			0.00	62.01	
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)			N	63.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	3.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
<b>Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010</b>						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151333		Period: From 01/01/2013 To 12/31/2013		Worksheet S-2 Part I Date/Time Prepared: 5/29/2014 3:29 pm	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
					1.00	2.00	
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
<b>Inpatient Psychiatric Facility PPS</b>							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	76.00
					1.00		
<b>Long Term Care Hospital PPS</b>							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N	80.00
<b>TEFRA Providers</b>							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00
				V	XIX		
				1.00	2.00		
<b>Title V and XIX Services</b>							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	97.00
<b>Rural Providers</b>							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			Y			106.00

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		V	XIX		
		1.00	2.00		
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	N
		1.00	2.00	3.00	
<b>Miscellaneous Cost Reporting Information</b>					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2		
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	206,953	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		
119.00	DO NOT USE THIS LINE				
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N		N
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		
<b>Transplant Center Information</b>					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				
<b>All Providers</b>					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151333	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/29/2014 3:29 pm			
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		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
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
161.10	CORF		N	N	N	161.10	
						1.00	
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00
						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)					144,473	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: 151333	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/29/2014 3:29 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	06/01/2014	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
Description		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	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	03/14/2014	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.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 151333

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

Worksheet S-2  
Part II  
Date/Time Prepared:  
5/29/2014 3:29 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.	N		N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been 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			Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			Y	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
				1.00	2.00
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TINA		SEVERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946		TSEVERS@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 151333

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

Worksheet S-2  
Part II  
Date/Time Prepared:  
5/29/2014 3:29 pm

		Part B	
		Date	
		4.00	
<b>PS&amp;R Data</b>			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		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)	03/14/2014	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	
<b>Cost Report Preparer Contact Information</b>			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HFS Supplemental Information		Provider CCN: 151333	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part IX Date/Time Prepared: 5/29/2014 3:29 pm
		Title V 1.00	Title XIX 2.00	
<b>TITLES V AND/OR XIX FOLLOWING MEDICARE</b>				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient 1.00	Outpatient 2.00	
<b>CRITICAL ACCESS HOSPITALS</b>				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V 1.00	Title XIX 2.00	
<b>RCE DISALLOWANCE</b>				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
<b>PASS THROUGH COST</b>				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151333

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/29/2014 3:29 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	19	6,935	43,704.00	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)		19	6,935	43,704.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	6	2,190	13,320.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,125	57,024.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						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
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		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: 151333

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/29/2014 3:29 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)	1,077	67	1,738			1.00
2.00 HMO and other (see instructions)	0	2				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	380	0	380			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	86			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,457	67	2,204			7.00
8.00 INTENSIVE CARE UNIT	326	0	525			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		0	0			13.00
14.00 Total (see instructions)	1,783	67	2,729	0.00	229.00	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						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
26.00 RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	229.00	27.00
28.00 Observation Bed Days		0	721			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151333

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/29/2014 3:29 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
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	373	15	1,600	1.00
2.00 HMO and other (see instructions)			0			2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	373	15	1,600	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00 SUBPROVIDER	0.00	0	0	0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						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
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151333	Period: From 01/01/2013 To 12/31/2013	Worksheet S-10 Date/Time Prepared: 5/29/2014 3:29 pm
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			1.00	
<b>Uncompensated and indigent care cost computation</b>				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.419222	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		1,176,049	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		341,918	5.00
6.00	Medicaid charges		5,585,020	6.00
7.00	Medicaid cost (line 1 times line 6)		2,341,363	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)		823,396	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)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
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)		823,396	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	1,341,636	0	1,341,636
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	562,443	0	562,443
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	562,443	0	562,443
				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?			24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit			0
26.00	Total bad debt expense for the entire hospital complex (see instructions)			4,606,337
27.00	Medicare bad debts for the entire hospital complex (see instructions)			448,623
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			4,157,714
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			1,743,005
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			2,305,448
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			3,128,844

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151333

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

Worksheet A  
Date/Time Prepared:  
5/29/2014 3:29 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		2,844,352		314,609	3,158,961
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	21,145	3,420,763		14,917	3,456,825
5.00	00500	ADMINISTRATIVE & GENERAL	1,729,963	2,472,039		192,942	4,394,944
7.00	00700	OPERATION OF PLANT	191,787	874,507		58,564	1,124,858
8.00	00800	LAUNDRY & LINEN SERVICE	22,090	74,236		96,326	96,326
9.00	00900	HOUSEKEEPING	299,595	91,715		391,310	391,310
10.00	01000	DIETARY	320,924	249,595		570,519	125,512
11.00	01100	CAFETERIA	0	0		445,007	445,007
13.00	01300	NURSING ADMINISTRATION	114,889	88,916		203,805	203,805
16.00	01600	MEDICAL RECORDS & LIBRARY	305,440	110,156		415,596	415,596
17.00	01700	SOCIAL SERVICE	0	149		0	149
17.01	01701	UTILIZATION REVIEW	79,541	1,880		81,421	81,421
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	890,979	52,818		331	944,128
31.00	03100	INTENSIVE CARE UNIT	783,070	34,033		429	817,532
41.00	04100	SUBPROVIDER - IRF	0	0		0	0
42.00	04200	SUBPROVIDER	0	0		0	0
43.00	04300	NURSERY	0	0		0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	422,063	711,192		11,345	1,144,600
51.00	05100	RECOVERY ROOM	82,831	12,656		95,487	95,487
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		0	0
53.00	05300	ANESTHESIOLOGY	568,833	100,411		669,244	669,244
54.00	05400	RADIOLOGY-DIAGNOSTIC	570,513	217,342		1,075	788,930
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	133,435		0	133,435
57.00	05700	CT SCAN	133,797	228,557		362,354	362,354
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0		0	0
60.00	06000	LABORATORY	561,659	1,170,085		1,731,744	1,731,744
60.01	06001	BLOOD LABORATORY	0	0		0	0
64.00	06400	INTRAVENOUS THERAPY	0	0		0	0
65.00	06500	RESPIRATORY THERAPY	315,661	107,770		1,023	424,454
66.00	06600	PHYSICAL THERAPY	0	433,640		158	433,798
67.00	06700	OCCUPATIONAL THERAPY	0	87,535		0	87,535
68.00	06800	SPEECH PATHOLOGY	0	8,389		0	8,389
69.00	06900	ELECTROCARDIOLOGY	47,497	55,684		103,181	103,181
69.01	06901	CARDIAC REHAB	87,804	2,065		89,869	89,869
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,326	47,577		-57,903	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		42,327	42,327
73.00	07300	DRUGS CHARGED TO PATIENTS	128,106	1,314,266		2,040,007	3,482,379
73.01	07301	ONCOLOGY	230,387	2,231,797		-2,039,227	422,957
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0		0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0
90.00	09000	CLINIC	7,365	322		7,687	7,687
91.00	09100	EMERGENCY	1,127,528	1,982,480		435	3,110,443
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0		0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0		0	0
110.00	11000	INTESTINAL ACQUISITION	0	0		0	0
111.00	11100	ISLET ACQUISITION	0	0		0	0
113.00	11300	INTEREST EXPENSE	0	0		0	0
114.00	11400	UTILIZATION REVIEW-SNF	0	0		0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,053,793	19,160,362		581,032	28,795,187
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,939,352	995,805		-581,032	3,354,125
193.00	19300	NONPAID WORKERS	0	0		0	0
193.01	19301	DME	0	0		0	0
193.02	19302	LACTATION CONSULTING	0	0		0	0
193.03	19303	DIABETIC COUNSELING	0	0		0	0
194.00	07950	VACANT SPACE	0	0		0	0
194.01	07951	BOARD OF HEALTH	0	0		0	0
200.00		TOTAL (SUM OF LINES 118-199)	11,993,145	20,156,167		0	32,149,312

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151333

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

Worksheet A  
Date/Time Prepared:  
5/29/2014 3:29 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-378,820	2,780,141	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-169	3,456,656	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-903,305	3,491,639	5.00
7.00	00700	OPERATION OF PLANT	-3,095	1,121,763	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	96,326	8.00
9.00	00900	HOUSEKEEPING	0	391,310	9.00
10.00	01000	DIETARY	-6,383	119,129	10.00
11.00	01100	CAFETERIA	-57,868	387,139	11.00
13.00	01300	NURSING ADMINISTRATION	0	203,805	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,099	408,497	16.00
17.00	01700	SOCIAL SERVICE	0	149	17.00
17.01	01701	UTILIZATION REVIEW	0	81,421	17.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	0	944,128	30.00
31.00	03100	INTENSIVE CARE UNIT	0	817,532	31.00
41.00	04100	SUBPROVIDER - I RF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	1,144,600	50.00
51.00	05100	RECOVERY ROOM	0	95,487	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-546,427	122,817	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,197	786,733	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	133,435	54.01
57.00	05700	CT SCAN	0	362,354	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	1,731,744	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	-4,390	420,064	65.00
66.00	06600	PHYSICAL THERAPY	-22,032	411,766	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	87,535	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,389	68.00
69.00	06900	ELECTROCARDIOLOGY	0	103,181	69.00
69.01	06901	CARDIAC REHAB	-1,440	88,429	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	42,327	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-41,320	3,441,059	73.00
73.01	07301	ONCOLOGY	-165,545	257,412	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	-475	7,212	90.00
91.00	09100	EMERGENCY	-1,452,705	1,657,738	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.10	09910	CORF	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,593,270	25,201,917	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,354,125	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	DME	0	0	193.01
193.02	19302	LACTATION CONSULTING	0	0	193.02
193.03	19303	DIABETIC COUNSELING	0	0	193.03
194.00	07950	VACANT SPACE	0	0	194.00
194.01	07951	BOARD OF HEALTH	0	0	194.01
200.00		TOTAL (SUM OF LINES 118-199)	-3,593,270	28,556,042	200.00

COST CENTERS USED IN COST REPORT		Provider CCN: 151333	Period: From 01/01/2013 To 12/31/2013	Worksheet Non-CMS W Date/Time Prepared: 5/29/2014 3:29 pm
Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	NEW CAP REL COSTS-BLDG & FIXT	00100		1.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
17.01	UTILIZATION REVIEW	01701		17.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
41.00	SUBPROVIDER - IRF	04100		41.00
42.00	SUBPROVIDER	04200		42.00
43.00	NURSERY	04300		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
54.01	NUCLEAR MEDICINE-DIAGNOSTIC	05401		54.01
57.00	CT SCAN	05700		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
59.00	CARDIAC CATHETERIZATION	05900		59.00
60.00	LABORATORY	06000		60.00
60.01	BLOOD LABORATORY	06001		60.01
64.00	INTRAVENOUS THERAPY	06400		64.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
69.01	CARDIAC REHAB	06901		69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
73.01	ONCOLOGY	07301		73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	RURAL HEALTH CLINIC	08800		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	08900		89.00
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10	CORF	09910		99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
109.00	PANCREAS ACQUISITION	10900		109.00
110.00	INTESTINAL ACQUISITION	11000		110.00
111.00	ISLET ACQUISITION	11100		111.00
113.00	INTEREST EXPENSE	11300		113.00
114.00	UTILIZATION REVIEW-SNF	11400		114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GI FT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
193.00	NONPAID WORKERS	19300		193.00
193.01	DME	19301		193.01
193.02	LACTATION CONSULTING	19302		193.02
193.03	DIABETIC COUNSELING	19303		193.03
194.00	VACANT SPACE	07950		194.00
194.01	BOARD OF HEALTH	07951		194.01
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS

Provider CCN: 151333

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

Worksheet A-6

Date/Time Prepared:  
5/29/2014 3:29 pm

		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
<b>A - CAFETERIA RECLASS</b>						
1.00	CAFETERIA		11.00	250,322	194,685	1.00
	TOTALS			250,322	194,685	
<b>B - EMPLOYEE PROMOTIONS</b>						
1.00	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	14,917	1.00
	TOTALS			0	14,917	
<b>C - INSURANCE RECLASS</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT		1.00	0	112,565	1.00
	TOTALS			0	112,565	
<b>D - DRUGS CHARGED</b>						
1.00	DRUGS CHARGED TO PATIENTS		73.00	0	2,039,238	1.00
	TOTALS			0	2,039,238	
<b>E - PPO DEPRECIATION</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT		1.00	0	16,243	1.00
	TOTALS			0	16,243	
<b>F - PHYSICIAN PRACTICE A&amp;G</b>						
1.00	ADMINISTRATIVE & GENERAL		5.00	319,171	0	1.00
	TOTALS			319,171	0	
<b>G - CLINIC RECLASS</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT		1.00	0	185,801	1.00
2.00	ADMINISTRATIVE & GENERAL		5.00	0	1,253	2.00
3.00	OPERATION OF PLANT		7.00	0	58,564	3.00
	TOTALS			0	245,618	
<b>H - IMPLANTABLE DEVICES</b>						
1.00	IMPL. DEV. CHARGED TO PATIENT		72.00	0	42,327	1.00
	TOTALS			0	42,327	
<b>I - MED SUPPLY COST RECLASS</b>						
1.00	ADULTS & PEDIATRICS		30.00	0	331	1.00
2.00	INTENSIVE CARE UNIT		31.00	0	429	2.00
3.00	OPERATING ROOM		50.00	0	11,345	3.00
4.00	RADIOLOGY-DIAGNOSTIC		54.00	0	1,075	4.00
5.00	RESPIRATORY THERAPY		65.00	0	1,023	5.00
6.00	PHYSICAL THERAPY		66.00	0	158	6.00
8.00	DRUGS CHARGED TO PATIENTS		73.00	0	769	8.00
9.00	ONCOLOGY		73.01	0	11	9.00
10.00	EMERGENCY		91.00	0	435	10.00
	TOTALS			0	15,576	
500.00	Grand Total: Increases			569,493	2,681,169	500.00

RECLASSIFICATIONS

Provider CCN: 151333

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

Worksheet A-6

Date/Time Prepared:  
5/29/2014 3:29 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	250,322	194,685	0		1.00
	TOTALS		250,322	194,685			
	B - EMPLOYEE PROMOTIONS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	14,917	0		1.00
	TOTALS		0	14,917			
	C - INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	112,565	12		1.00
	TOTALS		0	112,565			
	D - DRUGS CHARGED						
1.00	ONCOLOGY	73.01	0	2,039,238	0		1.00
	TOTALS		0	2,039,238			
	E - PPO DEPRECIATION						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	16,243	9		1.00
	TOTALS		0	16,243			
	F - PHYSICIAN PRACTICE A&G						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	319,171	0	0		1.00
	TOTALS		319,171	0			
	G - CLINIC RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	245,618	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	245,618			
	H - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	42,327	0		1.00
	TOTALS		0	42,327			
	I - MED SUPPLY COST RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	15,576	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
	TOTALS		0	15,576			
500.00	Grand Total: Decreases		569,493	2,681,169			500.00

RECLASSIFICATIONS

Provider CCN: 151333

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

Worksheet A-6  
Non-CMS Worksheet  
Date/Time Prepared:  
5/29/2014 3:29 pm

	Increases			Decreases			
	Cost Center	Line #	Salary	Cost Center	Line #	Salary	
	2.00	3.00	4.00	6.00	7.00	8.00	
<b>A - CAFETERIA RECLASS</b>							
1.00	CAFETERIA	11.00	250,322	DIETARY	10.00	250,322	1.00
	TOTALS		250,322	TOTALS		250,322	
<b>B - EMPLOYEE PROMOTIONS</b>							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	ADMINISTRATIVE & GENERAL	5.00	0	1.00
	TOTALS		0	TOTALS		0	
<b>C - INSURANCE RECLASS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	ADMINISTRATIVE & GENERAL	5.00	0	1.00
	TOTALS		0	TOTALS		0	
<b>D - DRUGS CHARGED</b>							
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	ONCOLOGY	73.01	0	1.00
	TOTALS		0	TOTALS		0	
<b>E - PPO DEPRECIATION</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	PHYSICIANS' PRIVATE OFFICES	192.00	0	1.00
	TOTALS		0	TOTALS		0	
<b>F - PHYSICIAN PRACTICE A&amp;G</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	319,171	PHYSICIANS' PRIVATE OFFICES	192.00	319,171	1.00
	TOTALS		319,171	TOTALS		319,171	
<b>G - CLINIC RECLASS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	PHYSICIANS' PRIVATE OFFICES	192.00	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0		0.00	0	2.00
3.00	OPERATION OF PLANT	7.00	0		0.00	0	3.00
	TOTALS		0	TOTALS		0	
<b>H - IMPLANTABLE DEVICES</b>							
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1.00
	TOTALS		0	TOTALS		0	
<b>I - MED SUPPLY COST RECLASS</b>							
1.00	ADULTS & PEDIATRICS	30.00	0	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	0		0.00	0	2.00
3.00	OPERATING ROOM	50.00	0		0.00	0	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0		0.00	0	4.00
5.00	RESPIRATORY THERAPY	65.00	0		0.00	0	5.00
6.00	PHYSICAL THERAPY	66.00	0		0.00	0	6.00
8.00	DRUGS CHARGED TO PATIENTS	73.00	0		0.00	0	8.00
9.00	ONCOLOGY	73.01	0		0.00	0	9.00
10.00	EMERGENCY	91.00	0		0.00	0	10.00
	TOTALS		0	TOTALS		0	
500.00	Grand Total : Increases		569,493	Grand Total : Decreases		569,493	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151333

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/29/2014 3:29 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	159,363	0	0	0	1.00
2.00	Land Improvements	297,477	0	0	0	2.00
3.00	Buildings and Fixtures	28,479,064	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	17,501,506	810,173	0	810,173	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	46,437,410	810,173	0	810,173	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	46,437,410	810,173	0	810,173	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	159,363	0			1.00
2.00	Land Improvements	297,477	0			2.00
3.00	Buildings and Fixtures	28,479,064	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	18,311,679	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	47,247,583	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	47,247,583	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151333

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/29/2014 3:29 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	NEW CAP REL COSTS-BLDG & FIXT	2,844,352	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	2,844,352	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,844,352				
3.00	Total (sum of lines 1-2)	0	2,844,352				

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151333

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/29/2014 3:29 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	NEW CAP REL COSTS-BLDG & FIXT	28,479,064	0	28,479,064	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	28,479,064	0	28,479,064	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,747,826	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	2,747,826	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	-80,250	112,565	0	0	2,780,141	1.00
3.00	Total (sum of lines 1-2)	-80,250	112,565	0	0	2,780,141	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151333

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

Worksheet A-8

Date/Time Prepared:  
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)				0NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)				0*** Cost Center Deleted ***	2.00	0	2.00
3.00 Investment income - other (chapter 2)				0	0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)				0	0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)				0	0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)				0	0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)				0	0.00	0	7.00
8.00 Television and radio service (chapter 21)				0	0.00	0	8.00
9.00 Parking lot (chapter 21)				0	0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-2,162,739		0		0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)				0	0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1			0		0	12.00
13.00 Laundry and linen service				0	0.00	0	13.00
14.00 Cafeteria-employees and guests				0	0.00	0	14.00
15.00 Rental of quarters to employee and others				0	0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients				0	0.00	0	16.00
17.00 Sale of drugs to other than patients				0	0.00	0	17.00
18.00 Sale of medical records and abstracts				0	0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)				0	0.00	0	19.00
20.00 Vending machines				0	0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)				0	0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments				0	0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3			0RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	-22,032		0PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)				0UTILIZATION REVIEW-SNF	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT				0NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP				0*** Cost Center Deleted ***	2.00	0	27.00
28.00 Non-physician Anesthetist				0*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant				0	0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3			0OCCUPATIONAL THERAPY	67.00		30.00
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			0SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest				0	0.00	0	32.00
33.00 DISCOUNTS	B	-6,228		0ADMINISTRATIVE & GENERAL	5.00	0	33.00

Provider CCN: 151333

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

Worksheet A-8

Date/Time Prepared:  
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
33.01	VENDOR REBATE/REFUND	B	-13,380	ADMINISTRATIVE & GENERAL	5.00	0 33.01
33.02	PHARMACY REBATES	B	-41,194	DRUGS CHARGED TO PATIENTS	73.00	0 33.02
33.03	SILVER RECOVERY	B	-2,197	RADIOLOGY-DIAGNOSTIC	54.00	0 33.03
33.04	DIABETIC COUNSELING OTHER REVENUE	B	-475	CLINIC	90.00	0 33.04
33.05	MEDICAL RECORDS FEES	B	-7,099	MEDICAL RECORDS & LIBRARY	16.00	0 33.05
33.06	VENDING MACHINES	B	-6,383	DIETARY	10.00	0 33.06
33.07	CAFETERIA SALES	B	-57,868	CAFETERIA	11.00	0 33.07
33.08	OTHER MISC INCOME	B	-7,937	ADMINISTRATIVE & GENERAL	5.00	0 33.08
33.09	OTHER MISC INCOME	B	-126	DRUGS CHARGED TO PATIENTS	73.00	0 33.09
33.10	OTHER MISC INCOME	B	-4,390	RESPIRATORY THERAPY	65.00	0 33.10
33.11	NONALLOWABLE INTEREST EXPENSE	A	-77,872	NEW CAP REL COSTS-BLDG & FIXT	1.00	11 33.11
33.12	INVESTMENT INCOME	B	-2,378	NEW CAP REL COSTS-BLDG & FIXT	1.00	11 33.12
33.13	LOBBYING OFFSET	A	-685	ADMINISTRATIVE & GENERAL	5.00	0 33.13
33.14	ADVERTISING OFFSET	A	-12,846	ADMINISTRATIVE & GENERAL	5.00	0 33.14
33.15	COMMUNITY RELATIONS OFFSET	A	-130,899	ADMINISTRATIVE & GENERAL	5.00	0 33.15
33.16	TELEPHONE WAGES	A	-700	ADMINISTRATIVE & GENERAL	5.00	0 33.16
33.17	TELEPHONE BENEFITS	A	-169	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.17
33.18	TELEPHONE OTHER	A	-769	ADMINISTRATIVE & GENERAL	5.00	0 33.18
33.19	TELEVISION OFFSET	A	-3,095	OPERATION OF PLANT	7.00	0 33.19
33.20	PHYSICIAN RECRUITMENT	A	-22,954	ADMINISTRATIVE & GENERAL	5.00	0 33.20
33.21	HAF EXPENSE	A	-705,937	ADMINISTRATIVE & GENERAL	5.00	0 33.21
33.22	MISC REVENUE-CBO	B	-970	ADMINISTRATIVE & GENERAL	5.00	0 33.22
33.23	ADVERTISING OFFSET	A	-3,378	ONCOLOGY	73.01	0 33.23
33.24	EHR DEPRECIATION	A	-298,570	NEW CAP REL COSTS-BLDG & FIXT	1.00	9 33.24
33.25			0		0.00	0 33.25
33.26			0		0.00	0 33.26
33.27			0		0.00	0 33.27
33.28			0		0.00	0 33.28
33.29			0		0.00	0 33.29
33.30			0		0.00	0 33.30
33.31			0		0.00	0 33.31
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,593,270			50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151333

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

Worksheet A-8-2

Date/Time Prepared:  
5/29/2014 3:29 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	91.00	EMERGENCY	1,731,949	1,452,705	279,244	0	0	1.00
2.00	60.00	LABORATORY	7,500	0	7,500	0	0	2.00
3.00	60.00	LABORATORY	90,000	0	90,000	0	0	3.00
4.00	73.01	ONCOLOGY	162,167	162,167	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	609,468	546,427	63,041	0	0	5.00
6.00	69.01	CARDIAC REHAB	1,440	1,440	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			2,602,524	2,162,739	439,785	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	73.01	ONCOLOGY	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	69.01	CARDIAC REHAB	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	91.00	EMERGENCY	0	0	0	1,452,705	1.00
2.00	60.00	LABORATORY	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	3.00
4.00	73.01	ONCOLOGY	0	0	0	162,167	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	546,427	5.00
6.00	69.01	CARDIAC REHAB	0	0	0	1,440	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	2,162,739	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151333		Period: From 01/01/2013 To 12/31/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/29/2014 3:29 pm	
				Physical Therapy		Cost	
						1.00	
<b>PART I - GENERAL INFORMATION</b>							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					268	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					277	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					6.40	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	2,744.00	2,500.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	75.96	56.97	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	37.98	37.98	28.49			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					208,434	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					142,425	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					350,859	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					350,859	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					350,859	23.00
<b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE</b>							
<b>Standard Travel Allowance</b>							
24.00	Therapists (line 3 times column 2, line 11)					10,179	24.00
25.00	Assistants (line 4 times column 3, line 11)					7,892	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					18,071	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					3,488	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					21,559	28.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					21,559	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					3,488	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
<b>PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE</b>							
<b>Standard Travel Expense</b>							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151333				Period: From 01/01/2013 To 12/31/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/29/2014 3:29 pm	
		Physical Therapy				Cost			
						1.00			
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0		46.00	
		Therapists	Assistants	Aides	Trainees	Total			
		1.00	2.00	3.00	4.00	5.00			
<b>PART V - OVERTIME COMPUTATION</b>									
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00		49.00	
<b>CALCULATION OF LIMIT</b>									
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00		51.00	
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>									
52.00	Adjusted hourly salary equivalency amount (see instructions)	75.96	56.97	0.00	0.00			52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0			53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0			54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0			55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0		56.00	
						1.00			
<b>Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT</b>									
57.00	Salary equivalency amount (from line 23)					350,859		57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					21,559		58.00	
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0		59.00	
60.00	Overtime allowance (from column 5, line 56)					0		60.00	
61.00	Equipment cost (see instructions)					0		61.00	
62.00	Supplies (see instructions)					0		62.00	
63.00	Total allowance (sum of lines 57-62)					372,418		63.00	
64.00	Total cost of outside supplier services (from your records)					394,450		64.00	
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					22,032		65.00	
<b>LINE 33 CALCULATION</b>									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					18,071		100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					3,488		100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27					21,559		100.02	
<b>LINE 34 CALCULATION</b>									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					3,488		101.00	
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0		101.01	
101.02	Line 34 = sum of lines 27 and 31					3,488		101.02	
<b>LINE 35 CALCULATION</b>									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0		102.00	
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0		102.01	
102.02	Line 35 = sum of lines 31 and 32					0		102.02	

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151333		Period: From 01/01/2013 To 12/31/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/29/2014 3:29 pm	
				Occupational Therapy		Cost	
						1.00	
<b>PART I - GENERAL INFORMATION</b>							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					1,476	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					6.40	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,476.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	72.01	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.01	36.01	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					106,287	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					106,287	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					106,287	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					106,287	23.00
<b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE</b>							
<b>Standard Travel Allowance</b>							
24.00	Therapists (line 3 times column 2, line 11)					53,151	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					53,151	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					9,446	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					62,597	28.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					62,597	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
<b>Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE</b>							
<b>Standard Travel Expense</b>							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151333		Period: From 01/01/2013 To 12/31/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/29/2014 3:29 pm	
				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
<b>PART V - OVERTIME COMPUTATION</b>							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
<b>CALCULATION OF LIMIT</b>							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
52.00	Adjusted hourly salary equivalency amount (see instructions)	72.01	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
<b>Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT</b>							
57.00	Salary equivalency amount (from line 23)					106,287	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					62,597	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					168,884	63.00
64.00	Total cost of outside supplier services (from your records)					87,535	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
<b>LINE 33 CALCULATION</b>							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					53,151	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					9,446	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					62,597	100.02
<b>LINE 34 CALCULATION</b>							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					9,446	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					9,446	101.02
<b>LINE 35 CALCULATION</b>							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151333	Period: From 01/01/2013 To 12/31/2013	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/29/2014 3:29 pm				
			Speech Pathology	Cost				
			1.00					
<b>PART I - GENERAL INFORMATION</b>								
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00	
2.00	Line 1 multiplied by 15 hours per week					780	2.00	
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					11	3.00	
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00	
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00	
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00	
7.00	Standard travel expense rate					6.40	7.00	
8.00	Optional travel expense rate per mile					0.00	8.00	
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	126.00	0.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	0.00	69.21	0.00	0.00	0.00	10.00	
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.61	34.61	0.00			11.00	
12.00	Number of travel hours (provider site)	0	0	0			12.00	
12.01	Number of travel hours (offsite)	0	0	0			12.01	
13.00	Number of miles driven (provider site)	0	0	0			13.00	
13.01	Number of miles driven (offsite)	0	0	0			13.01	
			1.00					
<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>								
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00	
15.00	Therapists (column 2, line 9 times column 2, line 10)					8,720	15.00	
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00	
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					8,720	17.00	
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00	
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00	
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					8,720	20.00	
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.								
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					69.21	21.00	
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					53,984	22.00	
23.00	Total salary equivalency (see instructions)					53,984	23.00	
<b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE</b>								
<b>Standard Travel Allowance</b>								
24.00	Therapists (line 3 times column 2, line 11)					381	24.00	
25.00	Assistants (line 4 times column 3, line 11)					0	25.00	
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					381	26.00	
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					70	27.00	
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					451	28.00	
<b>Optional Travel Allowance and Optional Travel Expense</b>								
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00	
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00	
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00	
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00	
33.00	Standard travel allowance and standard travel expense (line 28)					451	33.00	
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00	
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00	
<b>PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE</b>								
<b>Standard Travel Expense</b>								
36.00	Therapists (line 5 times column 2, line 11)					0	36.00	
37.00	Assistants (line 6 times column 3, line 11)					0	37.00	
38.00	Subtotal (sum of lines 36 and 37)					0	38.00	
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00	
<b>Optional Travel Allowance and Optional Travel Expense</b>								
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00	
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00	
42.00	Subtotal (sum of lines 40 and 41)					0	42.00	
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00	
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.								
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00	

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						Speech Pathology		Cost		
								1.00		
46.00 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)								0 46.00		
		Therapists	Assistants	Aides	Trainees	Total				
		1.00	2.00	3.00	4.00	5.00				
<b>PART V - OVERTIME COMPUTATION</b>										
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		47.00		
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		48.00		
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00		49.00		
<b>CALCULATION OF LIMIT</b>										
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		50.00		
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00		51.00		
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>										
52.00	Adjusted hourly salary equivalency amount (see instructions)	69.21	0.00	0.00	0.00			52.00		
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0			53.00		
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0			54.00		
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0			55.00		
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0		56.00		
								1.00		
<b>Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT</b>										
57.00	Salary equivalency amount (from line 23)						53,984		57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						451		58.00	
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0		59.00	
60.00	Overtime allowance (from column 5, line 56)						0		60.00	
61.00	Equipment cost (see instructions)						0		61.00	
62.00	Supplies (see instructions)						0		62.00	
63.00	Total allowance (sum of lines 57-62)						54,435		63.00	
64.00	Total cost of outside supplier services (from your records)						7,769		64.00	
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0		65.00	
<b>LINE 33 CALCULATION</b>										
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						381		100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						70		100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27						451		100.02	
<b>LINE 34 CALCULATION</b>										
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						70		101.00	
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0		101.01	
101.02	Line 34 = sum of lines 27 and 31						70		101.02	
<b>LINE 35 CALCULATION</b>										
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0		102.00	
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0		102.01	
102.02	Line 35 = sum of lines 31 and 32						0		102.02	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151333

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2014 3:29 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADM NI STRATI VE & GENERAL		
		RELATED COSTS NEW BLDG & FIXT					
	0	1.00	4.00	4A	5.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	2,780,141	2,780,141				1.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	3,456,656	0	3,456,656			4.00	
5.00 00500 ADM NI STRATI VE & GENERAL	3,491,639	378,529	592,155	4,462,323	4,462,323	5.00	
7.00 00700 OPERATION OF PLANT	1,121,763	317,708	55,422	1,494,893	276,865	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	96,326	18,571	6,384	121,281	22,462	8.00	
9.00 00900 HOUSEKEEPING	391,310	15,439	86,576	493,325	91,367	9.00	
10.00 01000 DI ETARY	119,129	81,123	20,402	220,654	40,867	10.00	
11.00 01100 CAFETERIA	387,139	44,064	72,338	503,541	93,259	11.00	
13.00 01300 NURSI NG ADM NI STRATI ON	203,805	18,269	33,200	255,274	47,279	13.00	
16.00 01600 MEDI CAL RECORDS & LIBRARY	408,497	114,831	88,265	611,593	113,271	16.00	
17.00 01700 SOCI AL SERVICE	149	0	0	149	28	17.00	
17.01 01701 UTI LI ZATI ON REVI EW	81,421	4,945	22,986	109,352	20,253	17.01	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDI ATRI CS	944,128	239,799	257,473	1,441,400	266,957	30.00	
31.00 03100 INTENSIVE CARE UNIT	817,532	78,046	226,290	1,121,868	207,778	31.00	
41.00 04100 SUBPROVIDER - I RF	0	0	0	0	0	41.00	
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00	
43.00 04300 NURSERY	0	0	0	0	0	43.00	
<b>ANCI LLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATI NG ROOM	1,144,600	256,419	121,967	1,522,986	282,068	50.00	
51.00 05100 RECOVERY ROOM	95,487	63,047	23,936	182,470	33,795	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00	
53.00 05300 ANESTHESI OLOGY	122,817	0	164,380	287,197	53,191	53.00	
54.00 05400 RADI OLOGY-DI AGNOSTI C	786,733	86,233	164,866	1,037,832	192,214	54.00	
54.01 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C	133,435	3,846	0	137,281	25,425	54.01	
57.00 05700 CT SCAN	362,354	36,262	38,664	437,280	80,987	57.00	
58.00 05800 MAGNETI C RESONANCE IMAGI NG (MRI )	0	0	0	0	0	58.00	
59.00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00	
60.00 06000 LABORATORY	1,731,744	67,909	162,307	1,961,960	363,369	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01	
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00 06500 RESPI RATORY THERAPY	420,064	18,763	91,219	530,046	98,168	65.00	
66.00 06600 PHYSI CAL THERAPY	411,766	88,321	0	500,087	92,620	66.00	
67.00 06700 OCCUPATI ONAL THERAPY	87,535	0	0	87,535	16,212	67.00	
68.00 06800 SPEECH PATHOLOGY	8,389	0	0	8,389	1,554	68.00	
69.00 06900 ELECTROCARDI OLOGY	103,181	2,747	13,726	119,654	22,161	69.00	
69.01 06901 CARDI AC REHAB	88,429	19,862	25,373	133,664	24,756	69.01	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	0	0	71.00	
72.00 07200 I MPL. DEV. CHARGED TO PATI ENT	42,327	0	0	42,327	7,839	72.00	
73.00 07300 DRUGS CHARGED TO PATI ENTS	3,441,059	21,318	37,020	3,499,397	648,113	73.00	
73.01 07301 ONCOLOGY	257,412	133,923	66,577	457,912	84,809	73.01	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800 RURAL HEALTH CLINI C	0	0	0	0	0	88.00	
89.00 08900 FEDERALLY QUALI FIED HEALTH CENTER	0	0	0	0	0	89.00	
90.00 09000 CLINI C	7,212	4,450	2,128	13,790	2,554	90.00	
91.00 09100 EMERGENCY	1,657,738	164,939	325,831	2,148,508	397,919	91.00	
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	0	0	0	0	92.00	
<b>OTHER REI MBURSABLE COST CENTERS</b>							
99.10 09910 CORF	0	0	0	0	0	99.10	
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00 10900 PANCREAS ACQUI SI TI ON	0	0	0	0	0	109.00	
110.00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0	0	110.00	
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111.00	
113.00 11300 I NTEREST EXPENSE	0	0	0	0	0	113.00	
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0	0	0	0	114.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	25,201,917	2,279,363	2,699,485	23,943,968	3,608,140	118.00
<b>NONREI MBURSABLE COST CENTERS</b>							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,104	0	13,104	2,427	190.00	
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES	3,354,125	422,182	757,171	4,533,478	839,626	192.00	
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00	
193.01 19301 DME	0	0	0	0	0	193.01	
193.02 19302 LACTATI ON CONSULTI NG	0	0	0	0	0	193.02	
193.03 19303 DI ABETI C COUNSELI NG	0	0	0	0	0	193.03	
194.00 07950 VACANT SPACE	0	42,498	0	42,498	7,871	194.00	
194.01 07951 BOARD OF HEALTH	0	22,994	0	22,994	4,259	194.01	
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)	28,556,042	2,780,141	3,456,656	28,556,042	4,462,323	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151333

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2014 3:29 pm

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	1,771,758				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	16,118	159,861			8.00
9.00	00900	HOUSEKEEPING	13,400	892	598,984		9.00
10.00	01000	DIETARY	70,408	663	25,062	357,654	10.00
11.00	01100	CAFETERIA	38,244	0	13,613	0	648,657
13.00	01300	NURSING ADMINISTRATION	15,855	0	5,644	0	5,065
16.00	01600	MEDICAL RECORDS & LIBRARY	99,663	0	35,475	0	44,968
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
17.01	01701	UTILIZATION REVIEW	4,292	0	1,528	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	208,124	34,560	74,083	291,093	82,131
31.00	03100	INTENSIVE CARE UNIT	67,737	26,699	24,111	66,561	65,876
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	222,549	24,998	79,217	0	38,990
51.00	05100	RECOVERY ROOM	54,719	0	19,478	0	6,214
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	8,717
54.00	05400	RADIOLOGY-DIAGNOSTIC	74,843	11,896	26,641	0	65,846
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	3,338	0	1,188	0	0
57.00	05700	CT SCAN	31,472	0	11,203	0	15,107
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	58,939	0	20,980	0	73,385
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	16,285	0	5,797	0	29,124
66.00	06600	PHYSICAL THERAPY	76,655	4,419	27,286	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	2,384	0	849	0	5,065
69.01	06901	CARDIAC REHAB	17,238	0	6,136	0	7,804
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	18,502	0	6,586	0	14,724
73.01	07301	ONCOLOGY	116,234	5,143	41,374	0	23,706
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	3,863	0	1,375	0	530
91.00	09100	EMERGENCY	143,152	38,704	50,956	0	89,522
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE					
114.00	11400	UTILIZATION REVIEW-SNF					
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,374,014	147,974	478,582	357,654	576,774
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,373	0	4,048	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	366,415	11,887	109,250	0	71,883
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	DME	0	0	0	0	0
193.02	19302	LACTATION CONSULTING	0	0	0	0	0
193.03	19303	DIABETIC COUNSELING	0	0	0	0	0
194.00	07950	VACANT SPACE	0	0	0	0	0
194.01	07951	BOARD OF HEALTH	19,956	0	7,104	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,771,758	159,861	598,984	357,654	648,657

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151333

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2014 3:29 pm

Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	UTILIZATION REVIEW	Subtotal	
		13.00	16.00	17.00	17.01	24.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	329,117					13.00
16.00	01600		904,970				16.00
17.00	01700			177			17.00
17.01	01701				135,425		17.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	83,560	435,572	144	110,222	3,027,846	30.00
31.00	03100	67,022		33	25,203	1,672,888	31.00
41.00	04100						41.00
42.00	04200						42.00
43.00	04300						43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	39,668	267,084			2,477,560	50.00
51.00	05100	6,322				302,998	51.00
52.00	05200						52.00
53.00	05300	8,868				357,973	53.00
54.00	05400		1,576			1,410,848	54.00
54.01	05401					167,232	54.01
57.00	05700					576,049	57.00
58.00	05800						58.00
59.00	05900						59.00
60.00	06000		297			2,478,930	60.00
60.01	06001						60.01
64.00	06400						64.00
65.00	06500					679,420	65.00
66.00	06600		3,004			704,071	66.00
67.00	06700					103,747	67.00
68.00	06800					9,943	68.00
69.00	06900					150,113	69.00
69.01	06901	7,940	1,695			199,233	69.01
71.00	07100						71.00
72.00	07200					50,166	72.00
73.00	07300					4,187,322	73.00
73.01	07301	24,118	17,639			770,935	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800						88.00
89.00	08900						89.00
90.00	09000	539				22,651	90.00
91.00	09100	91,080	177,538			3,137,379	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910						99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900						109.00
110.00	11000						110.00
111.00	11100						111.00
113.00	11300						113.00
114.00	11400						114.00
118.00		329,117	904,405	177	135,425	22,487,304	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000					30,952	190.00
192.00	19200		565			5,933,104	192.00
193.00	19300						193.00
193.01	19301						193.01
193.02	19302						193.02
193.03	19303						193.03
194.00	07950					50,369	194.00
194.01	07951					54,313	194.01
200.00							200.00
201.00							201.00
202.00		329,117	904,970	177	135,425	28,556,042	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151333

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2014 3:29 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
17.01	01701	UTILIZATION REVIEW		17.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	0	3,027,846
31.00	03100	INTENSIVE CARE UNIT	0	1,672,888
41.00	04100	SUBPROVIDER - I RF	0	0
42.00	04200	SUBPROVIDER	0	0
43.00	04300	NURSERY	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	0	2,477,560
51.00	05100	RECOVERY ROOM	0	302,998
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0
53.00	05300	ANESTHESIOLOGY	0	357,973
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,410,848
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	167,232
57.00	05700	CT SCAN	0	576,049
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0
60.00	06000	LABORATORY	0	2,478,930
60.01	06001	BLOOD LABORATORY	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0
65.00	06500	RESPIRATORY THERAPY	0	679,420
66.00	06600	PHYSICAL THERAPY	0	704,071
67.00	06700	OCCUPATIONAL THERAPY	0	103,747
68.00	06800	SPEECH PATHOLOGY	0	9,943
69.00	06900	ELECTROCARDIOLOGY	0	150,113
69.01	06901	CARDIAC REHAB	0	199,233
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	50,166
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,187,322
73.01	07301	ONCOLOGY	0	770,935
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800	RURAL HEALTH CLINIC	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0
90.00	09000	CLINIC	0	22,651
91.00	09100	EMERGENCY	0	3,137,379
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10	09910	CORF	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>				
109.00	10900	PANCREAS ACQUISITION	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0
111.00	11100	ISLET ACQUISITION	0	0
113.00	11300	INTEREST EXPENSE		
114.00	11400	UTILIZATION REVIEW-SNF		
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	22,487,304
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	30,952
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,933,104
193.00	19300	NONPAID WORKERS	0	0
193.01	19301	DME	0	0
193.02	19302	LACTATION CONSULTING	0	0
193.03	19303	DIABETIC COUNSELING	0	0
194.00	07950	VACANT SPACE	0	50,369
194.01	07951	BOARD OF HEALTH	0	54,313
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	28,556,042

COST ALLOCATION STATISTICS

Provider CCN: 151333

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

Worksheet Non-CMS W  
Date/Time Prepared:  
5/29/2014 3:29 pm

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	3		1.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4		4.00
5.00	ADMINISTRATIVE & GENERAL	-6		5.00
7.00	OPERATION OF PLANT	5		7.00
8.00	LAUNDRY & LINEN SERVICE	9		8.00
9.00	HOUSEKEEPING	33		9.00
10.00	DIETARY	11		10.00
11.00	CAFETERIA	12		11.00
13.00	NURSING ADMINISTRATION	14		13.00
16.00	MEDICAL RECORDS & LIBRARY	17		16.00
17.00	SOCIAL SERVICE	18		17.00
17.01	UTILIZATION REVIEW	11		17.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151333

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/29/2014 3: 29 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	378,529	378,529	0	378,529	5.00
7.00 00700	OPERATION OF PLANT	0	317,708	317,708	0	23,486	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	18,571	18,571	0	1,905	8.00
9.00 00900	HOUSEKEEPING	0	15,439	15,439	0	7,751	9.00
10.00 01000	DIETARY	0	81,123	81,123	0	3,467	10.00
11.00 01100	CAFETERIA	0	44,064	44,064	0	7,911	11.00
13.00 01300	NURSING ADMINISTRATION	0	18,269	18,269	0	4,011	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	114,831	114,831	0	9,609	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	2	17.00
17.01 01701	UTILIZATION REVIEW	0	4,945	4,945	0	1,718	17.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	0	239,799	239,799	0	22,646	30.00
31.00 03100	INTENSIVE CARE UNIT	0	78,046	78,046	0	17,626	31.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	0	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	0	256,419	256,419	0	23,928	50.00
51.00 05100	RECOVERY ROOM	0	63,047	63,047	0	2,867	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	4,512	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	86,233	86,233	0	16,305	54.00
54.01 05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	3,846	3,846	0	2,157	54.01
57.00 05700	CT SCAN	0	36,262	36,262	0	6,870	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	0	67,909	67,909	0	30,824	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	18,763	18,763	0	8,328	65.00
66.00 06600	PHYSICAL THERAPY	0	88,321	88,321	0	7,857	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	1,375	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	132	68.00
69.00 06900	ELECTROCARDIOLOGY	0	2,747	2,747	0	1,880	69.00
69.01 06901	CARDIAC REHAB	0	19,862	19,862	0	2,100	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	665	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	21,318	21,318	0	54,979	73.00
73.01 07301	ONCOLOGY	0	133,923	133,923	0	7,194	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000	CLINIC	0	4,450	4,450	0	217	90.00
91.00 09100	EMERGENCY	0	164,939	164,939	0	33,755	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10 09910	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	2,279,363	2,279,363	0	306,077	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,104	13,104	0	206	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	422,182	422,182	0	71,217	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01 19301	DME	0	0	0	0	0	193.01
193.02 19302	LACTATION CONSULTING	0	0	0	0	0	193.02
193.03 19303	DIABETIC COUNSELING	0	0	0	0	0	193.03
194.00 07950	VACANT SPACE	0	42,498	42,498	0	668	194.00
194.01 07951	BOARD OF HEALTH	0	22,994	22,994	0	361	194.01
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	2,780,141	2,780,141	0	378,529	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151333

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/29/2014 3:29 pm

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	341,194				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,104	23,580			8.00
9.00	00900	HOUSEKEEPING	2,580	132	25,902		9.00
10.00	01000	DIETARY	13,559	98	1,084	99,331	10.00
11.00	01100	CAFETERIA	7,365	0	589	0	59,929
13.00	01300	NURSING ADMINISTRATION	3,053	0	244	0	468
16.00	01600	MEDICAL RECORDS & LIBRARY	19,192	0	1,534	0	4,155
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
17.01	01701	UTILIZATION REVIEW	826	0	66	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	40,079	5,098	3,204	80,845	7,588
31.00	03100	INTENSIVE CARE UNIT	13,044	3,938	1,043	18,486	6,086
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	42,857	3,687	3,426	0	3,602
51.00	05100	RECOVERY ROOM	10,537	0	842	0	574
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	805
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,413	1,755	1,152	0	6,083
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	643	0	51	0	0
57.00	05700	CT SCAN	6,061	0	484	0	1,396
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	11,350	0	907	0	6,780
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	3,136	0	251	0	2,691
66.00	06600	PHYSICAL THERAPY	14,762	652	1,180	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	459	0	37	0	468
69.01	06901	CARDIAC REHAB	3,320	0	265	0	721
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	3,563	0	285	0	1,360
73.01	07301	ONCOLOGY	22,384	759	1,789	0	2,190
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	744	0	59	0	49
91.00	09100	EMERGENCY	27,567	5,708	2,203	0	8,272
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE					
114.00	11400	UTILIZATION REVIEW-SNF					
118.00		SUBTOTALS (SUM OF LINES 1-117)	264,598	21,827	20,695	99,331	53,288
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,190	0	175	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	70,563	1,753	4,725	0	6,641
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	DME	0	0	0	0	0
193.02	19302	LACTATION CONSULTING	0	0	0	0	0
193.03	19303	DIABETIC COUNSELING	0	0	0	0	0
194.00	07950	VACANT SPACE	0	0	0	0	0
194.01	07951	BOARD OF HEALTH	3,843	0	307	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	341,194	23,580	25,902	99,331	59,929

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151333

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/29/2014 3:29 pm

Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	UTILIZATION REVIEW	Subtotal	
		13.00	16.00	17.00	17.01	24.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	26,045					13.00
16.00	01600	0	149,321				16.00
17.00	01700	0	0	2			17.00
17.01	01701	0	0	0	7,555		17.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	6,613	71,870	2	6,149	483,893	30.00
31.00	03100	5,304	0	0	1,406	144,979	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	3,139	44,069	0	0	381,127	50.00
51.00	05100	500	0	0	0	78,367	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	702	0	0	0	6,019	53.00
54.00	05400	0	260	0	0	126,201	54.00
54.01	05401	0	0	0	0	6,697	54.01
57.00	05700	0	0	0	0	51,073	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	49	0	0	117,819	60.00
60.01	06001	0	0	0	0	0	60.01
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	0	0	33,169	65.00
66.00	06600	0	496	0	0	113,268	66.00
67.00	06700	0	0	0	0	1,375	67.00
68.00	06800	0	0	0	0	132	68.00
69.00	06900	0	0	0	0	5,591	69.00
69.01	06901	628	280	0	0	27,176	69.01
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	665	72.00
73.00	07300	0	0	0	0	81,505	73.00
73.01	07301	1,909	2,910	0	0	173,058	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	43	0	0	0	5,562	90.00
91.00	09100	7,207	29,294	0	0	278,945	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300						113.00
114.00	11400						114.00
118.00		26,045	149,228	2	7,555	2,116,621	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	15,675	190.00
192.00	19200	0	93	0	0	577,174	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
193.02	19302	0	0	0	0	0	193.02
193.03	19303	0	0	0	0	0	193.03
194.00	07950	0	0	0	0	43,166	194.00
194.01	07951	0	0	0	0	27,505	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		26,045	149,321	2	7,555	2,780,141	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151333	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 5/29/2014 3:29 pm
Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
17.01	01701	UTILIZATION REVIEW		17.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	483,893	30.00
31.00	03100	INTENSIVE CARE UNIT	144,979	31.00
41.00	04100	SUBPROVIDER - I RF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	381,127	50.00
51.00	05100	RECOVERY ROOM	78,367	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	6,019	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	126,201	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	6,697	54.01
57.00	05700	CT SCAN	51,073	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	117,819	60.00
60.01	06001	BLOOD LABORATORY	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	33,169	65.00
66.00	06600	PHYSICAL THERAPY	113,268	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,375	67.00
68.00	06800	SPEECH PATHOLOGY	132	68.00
69.00	06900	ELECTROCARDIOLOGY	5,591	69.00
69.01	06901	CARDIAC REHAB	27,176	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	665	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	81,505	73.00
73.01	07301	ONCOLOGY	173,058	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000	CLINIC	5,562	90.00
91.00	09100	EMERGENCY	278,945	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10	09910	CORF	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
109.00	10900	PANCREAS ACQUISITION	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	110.00
111.00	11100	ISLET ACQUISITION	0	111.00
113.00	11300	INTEREST EXPENSE	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,116,621	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,675	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	577,174	192.00
193.00	19300	NONPAID WORKERS	0	193.00
193.01	19301	DME	0	193.01
193.02	19302	LACTATION CONSULTING	0	193.02
193.03	19303	DIABETIC COUNSELING	0	193.03
194.00	07950	VACANT SPACE	43,166	194.00
194.01	07951	BOARD OF HEALTH	27,505	194.01
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118-201)	2,780,141	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151333

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

Worksheet B-1  
Date/Time Prepared:  
5/29/2014 3:29 pm

Cost Center Description	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)		
	NEW BLDG & FIXT (SQUARE FEET)						
	1.00	4.00	5A	5.00	7.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	101,201					1.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	11,961,674				4.00	
5.00 00500 ADMINISTRATIVE & GENERAL	13,779	2,049,134	-4,462,323	24,093,719		5.00	
7.00 00700 OPERATION OF PLANT	11,565	191,787	0	1,494,893	74,310	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	676	22,090	0	121,281	676	8.00	
9.00 00900 HOUSEKEEPING	562	299,595	0	493,325	562	9.00	
10.00 01000 DIETARY	2,953	70,602	0	220,654	2,953	10.00	
11.00 01100 CAFETERIA	1,604	250,322	0	503,541	1,604	11.00	
13.00 01300 NURSING ADMINISTRATION	665	114,889	0	255,274	665	13.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	4,180	305,440	0	611,593	4,180	16.00	
17.00 01700 SOCIAL SERVICE	0	0	0	149	0	17.00	
17.01 01701 UTILIZATION REVIEW	180	79,541	0	109,352	180	17.01	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	8,729	890,979	0	1,441,400	8,729	30.00	
31.00 03100 INTENSIVE CARE UNIT	2,841	783,070	0	1,121,868	2,841	31.00	
41.00 04100 SUBPROVIDER - I/R	0	0	0	0	0	41.00	
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00	
43.00 04300 NURSERY	0	0	0	0	0	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	9,334	422,063	0	1,522,986	9,334	50.00	
51.00 05100 RECOVERY ROOM	2,295	82,831	0	182,470	2,295	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00	
53.00 05300 ANESTHESIOLOGY	0	568,833	0	287,197	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	3,139	570,513	0	1,037,832	3,139	54.00	
54.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	140	0	0	137,281	140	54.01	
57.00 05700 CT SCAN	1,320	133,797	0	437,280	1,320	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00 06000 LABORATORY	2,472	561,659	0	1,961,960	2,472	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01	
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00 06500 RESPIRATORY THERAPY	683	315,661	0	530,046	683	65.00	
66.00 06600 PHYSICAL THERAPY	3,215	0	0	500,087	3,215	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	87,535	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0	0	0	8,389	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	100	47,497	0	119,654	100	69.00	
69.01 06901 CARDIAC REHAB	723	87,804	0	133,664	723	69.01	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	42,327	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	776	128,106	0	3,499,397	776	73.00	
73.01 07301 ONCOLOGY	4,875	230,387	0	457,912	4,875	73.01	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00	
90.00 09000 CLINIC	162	7,365	0	13,790	162	90.00	
91.00 09100 EMERGENCY	6,004	1,127,528	0	2,148,508	6,004	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10 09910 CORF	0	0	0	0	0	99.10	
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00	
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00	
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00	
113.00 11300 INTEREST EXPENSE						113.00	
114.00 11400 UTILIZATION REVIEW-SNF						114.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	82,972	9,341,493	-4,462,323	19,481,645	57,628	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	477	0	0	13,104	477	190.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	15,368	2,620,181	0	4,533,478	15,368	192.00	
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00	
193.01 19301 DME	0	0	0	0	0	193.01	
193.02 19302 LACTATION CONSULTING	0	0	0	0	0	193.02	
193.03 19303 DIABETIC COUNSELING	0	0	0	0	0	193.03	
194.00 07950 VACANT SPACE	1,547	0	0	42,498	0	194.00	
194.01 07951 BOARD OF HEALTH	837	0	0	22,994	837	194.01	
200.00	Cross Foot Adjustments					200.00	
201.00	Negative Cost Centers					201.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151333

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

Worksheet B-1  
Date/Time Prepared:  
5/29/2014 3:29 pm

Cost Center Description	1.00	4.00	5A	5.00	7.00	
	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
202.00 Cost to be allocated (per Wkst. B, Part I)	2,780,141	3,456,656		4,462,323	1,771,758	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	27.471478	0.288978		0.185207	23.842794	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)		0		378,529	341,194	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)		0.000000		0.015711	4.591495	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151333

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

Worksheet B-1

Date/Time Prepared:  
5/29/2014 3:29 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
		8.00	9.00	10.00	11.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800	37,116					8.00
9.00	00900	207	70,577				9.00
10.00	01000	154	2,953	2,821			10.00
11.00	01100	0	1,604	0	22,027		11.00
13.00	01300	0	665	0	172	10,985	13.00
16.00	01600	0	4,180	0	1,527	0	16.00
17.00	01700	0	0	0	0	0	17.00
17.01	01701	0	180	0	0	0	17.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	8,024	8,729	2,296	2,789	2,789	30.00
31.00	03100	6,199	2,841	525	2,237	2,237	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	5,804	9,334	0	1,324	1,324	50.00
51.00	05100	0	2,295	0	211	211	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	296	296	53.00
54.00	05400	2,762	3,139	0	2,236	0	54.00
54.01	05401	0	140	0	0	0	54.01
57.00	05700	0	1,320	0	513	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	2,472	0	2,492	0	60.00
60.01	06001	0	0	0	0	0	60.01
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	683	0	989	0	65.00
66.00	06600	1,026	3,215	0	0	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	100	0	172	0	69.00
69.01	06901	0	723	0	265	265	69.01
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	776	0	500	0	73.00
73.01	07301	1,194	4,875	0	805	805	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	162	0	18	18	90.00
91.00	09100	8,986	6,004	0	3,040	3,040	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300						113.00
114.00	11400						114.00
118.00		34,356	56,390	2,821	19,586	10,985	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	477	0	0	0	190.00
192.00	19200	2,760	12,873	0	2,441	0	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
193.02	19302	0	0	0	0	0	193.02
193.03	19303	0	0	0	0	0	193.03
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	837	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		159,861	598,984	357,654	648,657	329,117	202.00
203.00		4.307064	8.486958	126.782701	29.448268	29.960583	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151333

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

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
		8.00	9.00	10.00	11.00	13.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	23,580	25,902	99,331	59,929	26,045	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.635306	0.367003	35.211273	2.720706	2.370960	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151333

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

Worksheet B-1  
Date/Time Prepared:  
5/29/2014 3:29 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	UTILIZATION REVIEW (PATIENT DAYS)	
		16.00	17.00	17.01	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	121,699		16.00
17.00	01700	SOCIAL SERVICE	0	2,821	17.00
17.01	01701	UTILIZATION REVIEW	0	0	17.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	58,575	2,296	30.00
31.00	03100	INTENSIVE CARE UNIT	0	525	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	35,917	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	212	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	54.01
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	40	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	404	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	CARDIAC REHAB	228	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
73.01	07301	ONCOLOGY	2,372	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	23,875	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.10	09910	CORF	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	121,623	2,821	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	76	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	DME	0	0	193.01
193.02	19302	LACTATION CONSULTING	0	0	193.02
193.03	19303	DIABETIC COUNSELING	0	0	193.03
194.00	07950	VACANT SPACE	0	0	194.00
194.01	07951	BOARD OF HEALTH	0	0	194.01
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)	904,970	177	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.436133	0.062744	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151333

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

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description		MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	UTILIZATION REVIEW (PATIENT DAYS)	
		16.00	17.00	17.01	
204.00	Cost to be allocated (per Wkst. B, Part II)	149,321	2	7,555	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.226970	0.000709	2.678128	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151333

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/29/2014 3:29 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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		3,027,846	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT		1,672,888	0	0	31.00
41.00	04100 SUBPROVIDER - I RF		0	0	0	41.00
42.00	04200 SUBPROVIDER		0	0	0	42.00
43.00	04300 NURSERY		0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		2,477,560	0	0	50.00
51.00	05100 RECOVERY ROOM		302,998	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0	0	0	52.00
53.00	05300 ANESTHESIOLOGY		357,973	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		1,410,848	0	0	54.00
54.01	05401 NUCLEAR MEDICINE-DIAGNOSTIC		167,232	0	0	54.01
57.00	05700 CT SCAN		576,049	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	06000 LABORATORY		2,478,930	0	0	60.00
60.01	06001 BLOOD LABORATORY		0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	679,420	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	704,071	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	103,747	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	9,943	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY		150,113	0	0	69.00
69.01	06901 CARDIAC REHAB		199,233	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		50,166	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		4,187,322	0	0	73.00
73.01	07301 ONCOLOGY		770,935	0	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
90.00	09000 CLINIC		22,651	0	0	90.00
91.00	09100 EMERGENCY		3,137,379	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		766,264	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	09910 CORF		0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00	10900 PANCREAS ACQUISITION		0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION		0	0	0	110.00
111.00	11100 ISLET ACQUISITION		0	0	0	111.00
113.00	11300 INTEREST EXPENSE					113.00
114.00	11400 UTILIZATION REVIEW-SNF					114.00
200.00	Subtotal (see instructions)		23,253,568	0	0	200.00
201.00	Less Observation Beds		766,264			201.00
202.00	Total (see instructions)		22,487,304	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151333

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

Worksheet C  
Part I  
Date/Time Prepared:  
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		Title XVIII			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	1,727,482		1,727,482		30.00
31.00	03100	INTENSIVE CARE UNIT	737,989		737,989		31.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	0		0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	866,273	3,405,825	4,272,098	0.579940	50.00
51.00	05100	RECOVERY ROOM	52,719	412,792	465,511	0.650893	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	13,745	699,281	713,026	0.502048	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	431,729	4,260,740	4,692,469	0.300662	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	34,892	432,962	467,854	0.357445	54.01
57.00	05700	CT SCAN	460,063	9,193,540	9,653,603	0.059672	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	1,264,310	9,438,007	10,702,317	0.231626	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	866,946	496,366	1,363,312	0.498360	65.00
66.00	06600	PHYSICAL THERAPY	404,413	1,326,592	1,731,005	0.406741	66.00
67.00	06700	OCCUPATIONAL THERAPY	155,152	215,723	370,875	0.279736	67.00
68.00	06800	SPEECH PATHOLOGY	7,845	33,546	41,391	0.240221	68.00
69.00	06900	ELECTROCARDIOLOGY	31,767	736,193	767,960	0.195470	69.00
69.01	06901	CARDIAC REHAB	0	267,953	267,953	0.743537	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	841	164,664	165,505	0.303109	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,588,515	6,162,188	7,750,703	0.540251	73.00
73.01	07301	ONCOLOGY	638	591,484	592,122	1.301987	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	2,125	2,125	10.659294	90.00
91.00	09100	EMERGENCY	298,432	5,613,261	5,911,693	0.530707	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,243,627	1,243,627	0.616153	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0		99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
200.00		Subtotal (see instructions)	8,943,751	44,696,869	53,640,620		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	8,943,751	44,696,869	53,640,620		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151333	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/29/2014 3:29 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital Cost
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
	<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0.000000		54.01
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901 CARDIAC REHAB	0.000000		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	07301 ONCOLOGY	0.000000		73.01
	<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00	08800 RURAL HEALTH CLINIC			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
	<b>OTHER REIMBURSABLE COST CENTERS</b>			
99.10	09910 CORF			99.10
	<b>SPECIAL PURPOSE COST CENTERS</b>			
109.00	10900 PANCREAS ACQUISITION			109.00
110.00	11000 INTESTINAL ACQUISITION			110.00
111.00	11100 ISLET ACQUISITION			111.00
113.00	11300 INTEREST EXPENSE			113.00
114.00	11400 UTILIZATION REVIEW-SNF			114.00
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: 151333

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/29/2014 3:29 pm

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS		3,027,846	0	3,027,846	30.00	
31.00	03100 INTENSIVE CARE UNIT		1,672,888	0	1,672,888	31.00	
41.00	04100 SUBPROVIDER - I RF		0	0	0	41.00	
42.00	04200 SUBPROVIDER		0	0	0	42.00	
43.00	04300 NURSERY		0	0	0	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM		2,477,560	0	2,477,560	50.00	
51.00	05100 RECOVERY ROOM		302,998	0	302,998	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM		0	0	0	52.00	
53.00	05300 ANESTHESIOLOGY		357,973	0	357,973	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		1,410,848	0	1,410,848	54.00	
54.01	05401 NUCLEAR MEDICINE-DIAGNOSTIC		167,232	0	167,232	54.01	
57.00	05700 CT SCAN		576,049	0	576,049	57.00	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00	
60.00	06000 LABORATORY		2,478,930	0	2,478,930	60.00	
60.01	06001 BLOOD LABORATORY		0	0	0	60.01	
64.00	06400 INTRAVENOUS THERAPY		0	0	0	64.00	
65.00	06500 RESPIRATORY THERAPY	0	679,420	0	679,420	65.00	
66.00	06600 PHYSICAL THERAPY	0	704,071	0	704,071	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	103,747	0	103,747	67.00	
68.00	06800 SPEECH PATHOLOGY	0	9,943	0	9,943	68.00	
69.00	06900 ELECTROCARDIOLOGY		150,113	0	150,113	69.00	
69.01	06901 CARDIAC REHAB		199,233	0	199,233	69.01	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		50,166	0	50,166	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		4,187,322	0	4,187,322	73.00	
73.01	07301 ONCOLOGY		770,935	0	770,935	73.01	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC		0	0	0	88.00	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00	
90.00	09000 CLINIC		22,651	0	22,651	90.00	
91.00	09100 EMERGENCY		3,137,379	0	3,137,379	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		766,264	0	766,264	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910 CORF		0	0	0	99.10	
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900 PANCREAS ACQUISITION		0	0	0	109.00	
110.00	11000 INTESTINAL ACQUISITION		0	0	0	110.00	
111.00	11100 ISLET ACQUISITION		0	0	0	111.00	
113.00	11300 INTEREST EXPENSE					113.00	
114.00	11400 UTILIZATION REVIEW-SNF					114.00	
200.00	Subtotal (see instructions)		23,253,568	0	23,253,568	200.00	
201.00	Less Observation Beds		766,264		766,264	201.00	
202.00	Total (see instructions)		22,487,304	0	22,487,304	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151333

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/29/2014 3:29 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	1,727,482		1,727,482		30.00
31.00	03100	INTENSIVE CARE UNIT	737,989		737,989		31.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	0		0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	866,273	3,405,825	4,272,098	0.579940	50.00
51.00	05100	RECOVERY ROOM	52,719	412,792	465,511	0.650893	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	13,745	699,281	713,026	0.502048	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	431,729	4,260,740	4,692,469	0.300662	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	34,892	432,962	467,854	0.357445	54.01
57.00	05700	CT SCAN	460,063	9,193,540	9,653,603	0.059672	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	1,264,310	9,438,007	10,702,317	0.231626	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	866,946	496,366	1,363,312	0.498360	65.00
66.00	06600	PHYSICAL THERAPY	404,413	1,326,592	1,731,005	0.406741	66.00
67.00	06700	OCCUPATIONAL THERAPY	155,152	215,723	370,875	0.279736	67.00
68.00	06800	SPEECH PATHOLOGY	7,845	33,546	41,391	0.240221	68.00
69.00	06900	ELECTROCARDIOLOGY	31,767	736,193	767,960	0.195470	69.00
69.01	06901	CARDIAC REHAB	0	267,953	267,953	0.743537	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	841	164,664	165,505	0.303109	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,588,515	6,162,188	7,750,703	0.540251	73.00
73.01	07301	ONCOLOGY	638	591,484	592,122	1.301987	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	2,125	2,125	10.659294	90.00
91.00	09100	EMERGENCY	298,432	5,613,261	5,911,693	0.530707	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,243,627	1,243,627	0.616153	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0		99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
200.00		Subtotal (see instructions)	8,943,751	44,696,869	53,640,620		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	8,943,751	44,696,869	53,640,620		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 151333	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/29/2014 3:29 pm
			Title XIX	Hospital	Cost
Cost Center Description			PPS Inpatient Ratio		
INPATIENT ROUTINE SERVICE COST CENTERS			11.00		
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000		54.01
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIAC REHAB	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	07301	ONCOLOGY	0.000000		73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF			99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151333	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/29/2014 3:29 pm
		Title XVIII		Hospital
				Cost

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	381,127	4,272,098	0.089213	482,896	43,081	50.00
51.00	05100 RECOVERY ROOM	78,367	465,511	0.168346	31,433	5,292	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	6,019	713,026	0.008441	13,745	116	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	126,201	4,692,469	0.026894	193,216	5,196	54.00
54.01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	6,697	467,854	0.014314	19,746	283	54.01
57.00	05700 CT SCAN	51,073	9,653,603	0.005291	243,122	1,286	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	117,819	10,702,317	0.011009	700,748	7,715	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	33,169	1,363,312	0.024330	602,117	14,650	65.00
66.00	06600 PHYSICAL THERAPY	113,268	1,731,005	0.065435	155,606	10,182	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,375	370,875	0.003707	48,767	181	67.00
68.00	06800 SPEECH PATHOLOGY	132	41,391	0.003189	4,840	15	68.00
69.00	06900 ELECTROCARDIOLOGY	5,591	767,960	0.007280	20,134	147	69.00
69.01	06901 CARDIAC REHAB	27,176	267,953	0.101421	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	665	165,505	0.004018	841	3	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	81,505	7,750,703	0.010516	841,834	8,853	73.00
73.01	07301 ONCOLOGY	173,058	592,122	0.292267	452	132	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	5,562	2,125	2.617412	0	0	90.00
91.00	09100 EMERGENCY	278,945	5,911,693	0.047185	16,932	799	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,243,627	0.000000	0	0	92.00
200.00	Total (lines 50-199)	1,487,749	51,175,149		3,376,429	97,931	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151333

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/29/2014 3:29 pm

Cost Center Description		Title XVIII				Hospital		Total Cost (sum of col 1 through col 4)
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY	0	0	0	0	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 151333

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/29/2014 3:29 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Title XVIII			Hospital		Inpatient Program Charges	
			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)	Cost			
		6.00	7.00	8.00	9.00	10.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	4,272,098	0.000000	0.000000	482,896	50.00	
51.00	05100	RECOVERY ROOM	0	465,511	0.000000	0.000000	31,433	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00	
53.00	05300	ANESTHESIOLOGY	0	713,026	0.000000	0.000000	13,745	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,692,469	0.000000	0.000000	193,216	54.00	
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	467,854	0.000000	0.000000	19,746	54.01	
57.00	05700	CT SCAN	0	9,653,603	0.000000	0.000000	243,122	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00	
60.00	06000	LABORATORY	0	10,702,317	0.000000	0.000000	700,748	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01	
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0	1,363,312	0.000000	0.000000	602,117	65.00	
66.00	06600	PHYSICAL THERAPY	0	1,731,005	0.000000	0.000000	155,606	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	370,875	0.000000	0.000000	48,767	67.00	
68.00	06800	SPEECH PATHOLOGY	0	41,391	0.000000	0.000000	4,840	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	767,960	0.000000	0.000000	20,134	69.00	
69.01	06901	CARDIAC REHAB	0	267,953	0.000000	0.000000	0	69.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	165,505	0.000000	0.000000	841	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,750,703	0.000000	0.000000	841,834	73.00	
73.01	07301	ONCOLOGY	0	592,122	0.000000	0.000000	452	73.01	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00	
90.00	09000	CLINIC	0	2,125	0.000000	0.000000	0	90.00	
91.00	09100	EMERGENCY	0	5,911,693	0.000000	0.000000	16,932	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,243,627	0.000000	0.000000	0	92.00	
200.00		Total (lines 50-199)	0	51,175,149			3,376,429	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151333

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/29/2014 3:29 pm

Cost Center Description		Title XVIII			Hospital		Cost
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01	07301	ONCOLOGY	0	0	0	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151333

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/29/2014 3:29 pm

Cost Center Description		PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	Title XVIII	Hospital	Cost
		23.00	24.00			
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0		54.01
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIAC REHAB	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01	07301	ONCOLOGY	0	0		73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151333	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/29/2014 3:29 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
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0.579940	0	879,703	0	0 50.00
51.00 05100 RECOVERY ROOM	0.650893	0	109,220	0	0 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0 52.00
53.00 05300 ANESTHESIOLOGY	0.502048	0	70,705	0	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.300662	0	1,055,723	0	0 54.00
54.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0.357445	0	120,969	0	0 54.01
57.00 05700 CT SCAN	0.059672	0	2,656,527	0	0 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0 59.00
60.00 06000 LABORATORY	0.231626	0	3,299,644	0	0 60.00
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0 60.01
64.00 06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0 64.00
65.00 06500 RESPIRATORY THERAPY	0.498360	0	337,757	0	0 65.00
66.00 06600 PHYSICAL THERAPY	0.406741	0	582,873	0	0 66.00
67.00 06700 OCCUPATIONAL THERAPY	0.279736	0	76,165	0	0 67.00
68.00 06800 SPEECH PATHOLOGY	0.240221	0	17,722	0	0 68.00
69.00 06900 ELECTROCARDIOLOGY	0.195470	0	241,660	0	0 69.00
69.01 06901 CARDIAC REHAB	0.743537	0	112,872	0	0 69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.303109	0	34,741	0	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.540251	0	2,371,502	0	0 73.00
73.01 07301 ONCOLOGY	1.301987	0	194,514	0	0 73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0 88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0 89.00
90.00 09000 CLINIC	10.659294	0	0	0	0 90.00
91.00 09100 EMERGENCY	0.530707	0	1,273,629	0	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.616153	0	510,253	0	0 92.00
200.00 Subtotal (see instructions)		0	13,946,179	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	13,946,179	0	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151333	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/29/2014 3:29 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		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	510,175	0	50.00
51.00	05100 RECOVERY ROOM	71,091	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	35,497	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	317,416	0	54.00
54.01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	43,240	0	54.01
57.00	05700 CT SCAN	158,520	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	764,283	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	168,325	0	65.00
66.00	06600 PHYSICAL THERAPY	237,078	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	21,306	0	67.00
68.00	06800 SPEECH PATHOLOGY	4,257	0	68.00
69.00	06900 ELECTROCARDIOLOGY	47,237	0	69.00
69.01	06901 CARDIAC REHAB	83,925	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	10,530	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,281,206	0	73.00
73.01	07301 ONCOLOGY	253,255	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	675,924	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	314,394	0	92.00
200.00	Subtotal (see instructions)	4,997,659	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)	4,997,659	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151333	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/29/2014 3:29 pm
		Component CCN: 15Z333	Title XVIII	Swing Beds - SNF Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0.579940	0	0	0	0 50.00
51.00 05100 RECOVERY ROOM	0.650893	0	0	0	0 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0 52.00
53.00 05300 ANESTHESIOLOGY	0.502048	0	0	0	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.300662	0	0	0	0 54.00
54.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0.357445	0	0	0	0 54.01
57.00 05700 CT SCAN	0.059672	0	0	0	0 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0 59.00
60.00 06000 LABORATORY	0.231626	0	0	0	0 60.00
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0 60.01
64.00 06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0 64.00
65.00 06500 RESPIRATORY THERAPY	0.498360	0	0	0	0 65.00
66.00 06600 PHYSICAL THERAPY	0.406741	0	0	0	0 66.00
67.00 06700 OCCUPATIONAL THERAPY	0.279736	0	0	0	0 67.00
68.00 06800 SPEECH PATHOLOGY	0.240221	0	0	0	0 68.00
69.00 06900 ELECTROCARDIOLOGY	0.195470	0	0	0	0 69.00
69.01 06901 CARDIAC REHAB	0.743537	0	0	0	0 69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.303109	0	0	0	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.540251	0	0	0	0 73.00
73.01 07301 ONCOLOGY	1.301987	0	0	0	0 73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0 88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0 89.00
90.00 09000 CLINIC	10.659294	0	0	0	0 90.00
91.00 09100 EMERGENCY	0.530707	0	0	0	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.616153	0	0	0	0 92.00
200.00 Subtotal (see instructions)		0	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	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151333	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/29/2014 3:29 pm
		Component CCN: 15Z333	Title XVIII	Swing Beds - SNF
				Cost

Cost Center Description	Costs		Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	54.01
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	60.01
64.00 06400 INTRAVENOUS THERAPY	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
69.01 06901 CARDIAC REHAB	0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
73.01 07301 ONCOLOGY	0	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00 08800 RURAL HEALTH CLINIC	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00 09000 CLINIC	0	0	90.00
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00 Subtotal (see instructions)	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151333	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/29/2014 3:29 pm
Cost Center Description			Cost	
			1.00	
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,925	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,459	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,738	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		380	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		86	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,077	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)		380	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		123.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,027,846	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)		10,606	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)		414,462	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,613,384	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,613,384	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,062.78	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,144,614	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)		1,144,614	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151333		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
		Title XVIII		Hospital		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	1,672,888	525	3,186.45	326	1,038,783		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)					1,396,116		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,579,513		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					403,856		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)					403,856		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)						721	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,062.78	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						766,264	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151333		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/29/2014 3:29 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: 151333	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/29/2014 3:29 pm
Cost Center Description			Cost	
			1.00	
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,925	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,459	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,738	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		86	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)		67	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,027,846	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,027,846	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,027,846	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,231.33	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		82,499	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)		82,499	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151333		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
Title XIX		Hospital		Cost			
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	1,672,888	525	3,186.45	0	0		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)					65,199		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					147,698		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						721	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,231.33	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						887,789	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151333		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/29/2014 3:29 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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151333	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/29/2014 3:29 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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		850,748	30.00
31.00	03100	INTENSIVE CARE UNIT		519,857	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.579940	482,896	50.00
51.00	05100	RECOVERY ROOM	0.650893	31,433	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.502048	13,745	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.300662	193,216	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.357445	19,746	54.01
57.00	05700	CT SCAN	0.059672	243,122	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.231626	700,748	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.498360	602,117	65.00
66.00	06600	PHYSICAL THERAPY	0.406741	155,606	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.279736	48,767	67.00
68.00	06800	SPEECH PATHOLOGY	0.240221	4,840	68.00
69.00	06900	ELECTROCARDIOLOGY	0.195470	20,134	69.00
69.01	06901	CARDIAC REHAB	0.743537	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.303109	841	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.540251	841,834	73.00
73.01	07301	ONCOLOGY	1.301987	452	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	10.659294	0	90.00
91.00	09100	EMERGENCY	0.530707	16,932	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.616153	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,376,429	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)		3,376,429	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151333	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3	
		Component CCN: 15Z333		Date/Time Prepared: 5/29/2014 3:29 pm	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.579940	0	50.00
51.00	05100	RECOVERY ROOM	0.650893	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.502048	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.300662	11,639	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.357445	1,598	54.01
57.00	05700	CT SCAN	0.059672	17,899	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.231626	67,873	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.498360	68,646	65.00
66.00	06600	PHYSICAL THERAPY	0.406741	157,537	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.279736	83,890	67.00
68.00	06800	SPEECH PATHOLOGY	0.240221	2,045	68.00
69.00	06900	ELECTROCARDIOLOGY	0.195470	1,074	69.00
69.01	06901	CARDIAC REHAB	0.743537	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.303109	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.540251	153,182	73.00
73.01	07301	ONCOLOGY	1.301987	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	10.659294	0	90.00
91.00	09100	EMERGENCY	0.530707	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.616153	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		565,383	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)		565,383	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151333	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/29/2014 3:29 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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		48,227	30.00
31.00	03100	INTENSIVE CARE UNIT		11,881	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.579940	10,441	50.00
51.00	05100	RECOVERY ROOM	0.650893	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.502048	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.300662	8,643	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.357445	0	54.01
57.00	05700	CT SCAN	0.059672	21,364	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.231626	52,984	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.498360	8,364	65.00
66.00	06600	PHYSICAL THERAPY	0.406741	4,436	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.279736	184	67.00
68.00	06800	SPEECH PATHOLOGY	0.240221	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.195470	6,486	69.00
69.01	06901	CARDIAC REHAB	0.743537	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.303109	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.540251	51,751	73.00
73.01	07301	ONCOLOGY	1.301987	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	10.659294	0	90.00
91.00	09100	EMERGENCY	0.530707	14,600	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.616153	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		179,253	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)		179,253	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151333	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/29/2014 3:29 pm
		Title XVII	Hospital	Cost
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			4,997,659 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)			4,997,659 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			5,047,636 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)			34,430 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,158,592 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			2,854,614 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			2,854,614 30.00
31.00	Primary payer payments			2,246 31.00
32.00	Subtotal (line 30 minus line 31)			2,852,368 32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			451,816 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			397,598 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			280,701 36.00
37.00	Subtotal (see instructions)			3,249,966 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)			3,249,966 40.00
40.01	Sequestration adjustment (see instructions)			49,074 40.01
41.00	Interim payments			3,457,138 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			-256,246 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00
				Overrides
				1.00
<b>WORKSHEET OVERRIDE VALUES</b>				
112.00	Override of Ancillary service charges (line 12)			0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151333

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/29/2014 3:29 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		2,763,814		3,392,938	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	06/25/2013	217,800	06/25/2013	64,200	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)		217,800		64,200	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)		2,981,614		3,457,138	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		316,109		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		256,246	6.02	
7.00	Total Medicare program liability (see instructions)		3,297,723		3,200,892	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: 151333  
Component CCN: 15Z333

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/29/2014 3:29 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		532,349		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	06/25/2013	35,000		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)		35,000		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)		567,349		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		53,003		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		620,352		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 151333	Period: From 01/01/2013 To 12/31/2013	Worksheet E-1 Part II Date/Time Prepared: 5/29/2014 3:29 pm
		Title XVIII	Hospital	Cost
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			1,600 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			1,403 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			0 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			2,263 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			53,640,620 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			1,341,636 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			144,473 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			120,779 8.00
9.00	Sequestration adjustment amount (see instructions)			2,416 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			118,363 10.00
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			118,363 32.00
				<b>Overrides</b>
				1.00
<b>CONTRACTOR OVERRIDES</b>				
108.00	Override of HIT payment			0 108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151333  
Component CCN: 15Z333

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

Worksheet E-2  
Date/Time Prepared:  
5/29/2014 3:29 pm

		Title XVIII		Swing Beds - SNF	
		Part A	Part B	Cost	
		1.00	2.00		
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient routine services - swing bed-SNF (see instructions)	407,895	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)	228,332	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	380	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)	636,227	0	8.00	
9.00	Primary payer payments (see instructions)	0	0	9.00	
10.00	Subtotal (line 8 minus line 9)	636,227	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)	636,227	0	12.00	
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	6,364	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)	629,863	0	15.00	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00	
17.00	Allowable bad debts (see instructions)	0	0	17.00	
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01	
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00	
19.00	Total (see instructions)	629,863	0	19.00	
19.01	Sequestration adjustment (see instructions)	9,511	0	19.01	
20.00	Interim payments	567,349	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	53,003	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: 151333	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part V Date/Time Prepared: 5/29/2014 3:29 pm
		Title XVIII	Hospital	Cost
		1.00		
<b>PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)</b>				
1.00	Inpatient services		3,579,513	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)		3,579,513	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		3,615,308	6.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
<b>Customary charges</b>				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	17.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		3,615,308	19.00
20.00	Deductibles (exclude professional component)		318,051	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		3,297,257	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		3,297,257	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		57,983	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		51,025	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		29,739	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		3,348,282	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)		3,348,282	30.00
30.01	Sequestration adjustment (see instructions)		50,559	30.01
31.00	Interim payments		2,981,614	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		316,109	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151333	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2014 3:29 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		147,698		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		147,698	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		147,698	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		60,108		8.00
9.00	Ancillary service charges		179,253	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		239,361	0	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		239,361	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		91,663	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		147,698	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		147,698	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		147,698	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		147,698	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		147,698	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		147,698	0	40.00
41.00	Interim payments		137,420	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		10,278	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0	43.00

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

Provider CCN: 151333

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

Worksheet G

Date/Time Prepared:  
5/29/2014 3:29 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	2,683,685	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	8,040,682	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,103,990	0	0	0	6.00
7.00	Inventory	926,674	0	0	0	7.00
8.00	Prepaid expenses	188,227	0	0	0	8.00
9.00	Other current assets	2,579,542	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)	10,314,820	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	456,842	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	-235,817	0	0	0	14.00
15.00	Buildings	28,624,013	0	0	0	15.00
16.00	Accumulated depreciation	-17,699,655	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	18,311,680	0	0	0	23.00
24.00	Accumulated depreciation	-14,318,436	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)	15,138,627	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	25,453,447	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	832,402	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,002,325	0	0	0	38.00
39.00	Payroll taxes payable	94,814	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,718	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	1,488,680	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,420,939	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	11,394,186	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	11,394,186	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	14,815,125	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	10,638,322	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	10,638,322	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	25,453,447	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151333

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

Worksheet G-1

Date/Time Prepared:  
5/29/2014 3:29 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		12,654,200		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-1,826,663			2.00
3.00	Total (sum of line 1 and line 2)		10,827,537		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		10,827,537		0	11.00
12.00	Deductions (debit adjustments)	0		0		12.00
13.00	DIFF IN BEG BAL AND RESTRICTED FUNDS	189,215		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		189,215		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		10,638,322		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments)		0			12.00
13.00	DIFF IN BEG BAL AND RESTRICTED FUNDS		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: 151333

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/29/2014 3:29 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	1,982,737		1,982,737	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	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)	1,982,737		1,982,737	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	1,512,687		1,512,687	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)	1,512,687		1,512,687	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,495,424		3,495,424	17.00
18.00	Ancillary services	6,601,423	38,741,026	45,342,449	18.00
19.00	Outpatient services	212,469	9,294,512	9,506,981	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIANS PRIVATE OFFICE	448,697	5,584,779	6,033,476	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	10,758,013	53,620,317	64,378,330	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		32,149,312		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		32,149,312		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151333

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

Worksheet G-3

Date/Time Prepared:  
5/29/2014 3:29 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	64,378,330	1.00
2.00	Less contractual allowances and discounts on patients' accounts	35,807,214	2.00
3.00	Net patient revenues (line 1 minus line 2)	28,571,116	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	32,149,312	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,578,196	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING AND NONOPERATING	1,753,967	24.00
25.00	Total other income (sum of lines 6-24)	1,753,967	25.00
26.00	Total (line 5 plus line 25)	-1,824,229	26.00
27.00	MISC	2,434	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	2,434	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,826,663	29.00