

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet S Parts I-III Date/Time Prepared: 5/27/2014 8:05 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/27/2014 Time: 8:05 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by REID HOSPITAL & HEALTH CARE SERVICES (150048) for the cost reporting period beginning 01/01/2013 and ending 12/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-898,103	347,937	98,360	0	1.00
2.00 Subprovider - IPF	0	-3,856	1,087		0	2.00
3.00 Subprovider - IRF	0	-17,290	78		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	-919,249	349,102	98,360	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 150048		Period: From 01/01/2013 To 12/31/2013		Worksheet S-2 Part I Date/Time Prepared: 5/27/2014 8:01 am		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1401 CHESTER BOULEVARD			PO Box:							
2.00	City: RICHMOND			State: IN		Zip Code: 47374		County: WAYNE			
				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			REID HOSPITAL & HEALTH CARE SERVICES	150048	99915	1	07/01/1966	N	P	0
4.00	Subprovider - IPF			SUBPROVIDER	15S048	99915	4	01/01/2001	N	P	0
5.00	Subprovider - IRF			REHAB UNIT	15T048	99915	5	01/01/2003	N	P	0
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF										
8.00	Swing Beds - NF										
9.00	Hospital-Based SNF										
10.00	Hospital-Based NF										
11.00	Hospital-Based OLTC										
12.00	Hospital-Based HHA										
13.00	Separately Certified ASC										
14.00	Hospital-Based Hospice			HOSPICE	151524	99915		11/03/1993			
15.00	Hospital-Based Health Clinic - RHC										
16.00	Hospital-Based Health Clinic - FQHC										
17.00	Hospital-Based (CMHC) I										
18.00	Renal Dialysis										
19.00	Other										
								From:	To:		
								1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)							01/01/2013	12/31/2013		
21.00	Type of Control (see instructions)							2		21.00	
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.							Y	N		
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)							N	Y		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							3	N		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days		
				1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			2,417	592	410	64	2,847	0		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.			11	30	0	0	0	0		
								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.							1		35.00	

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		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.	01/01/2013	12/31/2013	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)			V 1.00	XVIII 2.00	XIX 3.00
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	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)	Y				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)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06
		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		
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)			0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)			0.00	62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)			N	63.00	
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	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 Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y			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)			N		0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y			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)			N	N	0	76.00
					1.00		
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N	80.00
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N	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	
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N		Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00		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		97.00
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			N			106.00

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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.	N	N	N	N	109.00	
		1.00	2.00	3.00			
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0	115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		Y			116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		N			117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1			118.00	
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	549,082	116,985			0	118.01
		1.00	2.00				
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N			118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		Y		N	120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y			121.00	
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y			140.00	

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1.00		2.00		3.00										
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.														
141.00	Name:	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.						Y 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						
						1.00								
Multi campus														
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N		165.00					
		Name		County		State		Zip Code		CBSA		FTE/Campus		
		0		1.00		2.00		3.00		4.00		5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5										0.00		166.00	
						1.00								
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)								0 168.00					
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)						1.00		169.00					
						Beginning		Ending						
						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)						07/01/2013		09/28/2013		170.00			

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/27/2014 8:01 am	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			Y	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
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		03/14/2013	Y
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N			N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N			N
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N			N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 150048

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

Worksheet S-2
Part II
Date/Time Prepared:
5/27/2014 8:01 am

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			Y	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			Y	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.			Y	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BKD		LLP	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5025810435		LV COSTREPORTS@BKD.COM	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		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)	03/14/2013	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	COST REPORT GROUP	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150048

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

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2014 8:01 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	135	49,275	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		135	49,275	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	30	10,950	0.00	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)		165	60,225	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	38	13,870		0	16.00
17.00 SUBPROVIDER - IRF	41.00	20	7,300		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		223				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: 150048

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

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2014 8:01 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	17,650	1,543	30,401			1.00
2.00 HMO and other (see instructions)	3,028	3,913				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	177	30				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	17,650	1,543	30,401			7.00
8.00 INTENSIVE CARE UNIT	3,058	268	6,053			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		606	1,896			13.00
14.00 Total (see instructions)	20,708	2,417	38,350	0.00	2,001.29	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	8,314	432	10,282	0.00	63.11	16.00
17.00 SUBPROVIDER - IRF	2,299	11	3,056	0.00	22.45	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	9,986	1,835	15,446	0.00	17.66	24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	2,104.51	27.00
28.00 Observation Bed Days		670	3,439			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			524			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	120			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: 150048

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

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2014 8:01 am

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	5,190	536	10,565	1.00
2.00 HMO and other (see instructions)			706			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	5,190	536	10,565	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	491	29	692	16.00
17.00 SUBPROVIDER - IRF	0.00	0	170	1	239	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 150048		Period: From 01/01/2013 To 12/31/2013		Worksheet S-3 Part II Date/Time Prepared: 5/27/2014 8:01 am	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	117,422,398	0	117,422,398	4,377,380.97	26.82	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		52,041,205	103,804	52,145,009	1,344,094.60	38.80	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor (see instructions)		5,873,390	0	5,873,390	159,260.07	36.88	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		18,075,476	0	18,075,476			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		10,301,934	0	10,301,934			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FOHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	1,304,167	0	1,304,167	43,130.86	30.24	26.00
27.00	Administrative & General	5.00	9,255,828	-115,806	9,140,022	435,760.53	20.97	27.00
28.00	Administrative & General under contract (see inst.)		165,466	0	165,466	848.85	194.93	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,741,299	0	1,741,299	84,522.47	20.60	30.00
31.00	Laundry & Linen Service	8.00	384,188	-77,960	306,228	31,324.24	9.78	31.00
32.00	Housekeeping	9.00	1,539,271	0	1,539,271	114,631.55	13.43	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	2,441,647	-1,343,800	1,097,847	82,588.35	13.29	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,139,980	1,139,980	72,332.58	15.76	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	984,922	230,504	1,215,426	25,456.78	47.74	38.00
39.00	Central Services and Supply	14.00	588,753	0	588,753	40,903.84	14.39	39.00
40.00	Pharmacy	15.00	3,307,575	0	3,307,575	111,074.44	29.78	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150048

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

Worksheet S-3
Part II
Date/Time Prepared:
5/27/2014 8:01 am

		Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
42.00	Soci al Servi ce	17.00	645,070	0	645,070	23,981.81	26.90	42.00
43.00	Other General Servi ce	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150048

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

Worksheet S-3
Part III
Date/Time Prepared:
5/27/2014 8:01 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	117,587,864	0	117,587,864	4,378,229.82	26.86	1.00
2.00	Excluded area salaries (see instructions)	52,041,205	103,804	52,145,009	1,344,094.60	38.80	2.00
3.00	Subtotal salaries (line 1 minus line 2)	65,546,659	-103,804	65,442,855	3,034,135.22	21.57	3.00
4.00	Subtotal other wages & related costs (see inst.)	5,873,390	0	5,873,390	159,260.07	36.88	4.00
5.00	Subtotal wage-related costs (see inst.)	18,075,476	0	18,075,476	0.00	27.62	5.00
6.00	Total (sum of lines 3 thru 5)	89,495,525	-103,804	89,391,721	3,193,395.29	27.99	6.00
7.00	Total overhead cost (see instructions)	22,358,186	-167,082	22,191,104	1,066,556.30	20.81	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet S-3 Part IV Date/Time Prepared: 5/27/2014 8:01 am
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	5,076,357	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	3,400,699	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration Fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	10,752,267	8.00
9.00	Prescription Drug Plan	828,857	9.00
10.00	Dental, Hearing and Vision Plan	588,331	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	67,554	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	0	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	7,402,925	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	260,420	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	28,377,410	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150048

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

Worksheet S-3
Part V
Date/Time Prepared:
5/27/2014 8:01 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL IDENTIFICATION DATA		Provider CCN: 150048 Component CCN: 151524	Period: From 01/01/2013 To 12/31/2013	Worksheet S-9 Parts I & II Date/Time Prepared: 5/27/2014 8:01 am
		Hospice I		

	Unduplicated Days	Hospice I					Total (sum of col.s. 1, 2 & 5)	
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other		
		1.00	2.00	3.00	4.00	5.00		
PART I - ENROLLMENT DAYS								
1.00	Continuous Home Care	0	12	0	0	14	26	1.00
2.00	Routine Home Care	9,322	1,773	7,275	44	3,538	14,633	2.00
3.00	Inpatient Respite Care	27	14	0	0	4	45	3.00
4.00	General Inpatient Care	637	36	0	0	69	742	4.00
5.00	Total Hospice Days	9,986	1,835	7,275	44	3,625	15,446	5.00
Part II - CENSUS DATA								
6.00	Number of Patients Receiving Hospice Care	269	17	96	9	114	400	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	559.00		0.00				7.00
8.00	Average Length of Stay (line 5/line 6)	37.12	107.94	75.78	4.89	31.80	38.62	8.00
9.00	Unduplicated Census Count	269	39	96	9	114	422	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet S-10 Date/Time Prepared: 5/27/2014 8:01 am
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				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.323421		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		20,801,706		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0		5.00
6.00	Medicaid charges		69,344,816		6.00
7.00	Medicaid cost (line 1 times line 6)		22,427,570		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		1,625,864		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		8,771		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		1,625,864		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	17,534,638	7,402,892	24,937,530	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	5,671,070	2,394,251	8,065,321	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	5,671,070	2,394,251	8,065,321	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?				24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			31,091,990	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			1,337,676	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			29,754,314	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			9,623,170	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			17,688,491	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			19,314,355	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150048

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

Worksheet A
Date/Time Prepared:
5/27/2014 8:01 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	0	28,166,402	28,166,402	1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE	0	0	1,260,004	1,260,004	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,304,167	21,904,745	23,208,912	23,443,994	4.00
5.01	00510	NONPATIENT TELEPHONES	241,609	22,856	264,465	264,465	5.01
5.02	00520	DATA PROCESSING	3,175,324	15,620,013	18,795,337	19,053,244	5.02
5.03	00530	PURCHASING RECEIVING AND STORES	786,830	770,432	1,557,262	1,557,738	5.03
5.04	00540	ADMINITTING	0	2,094,099	2,094,099	2,094,099	5.04
5.05	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	3,157,659	3,157,659	3,088,693	5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	5,052,065	11,942,281	16,994,346	17,913,525	5.06
7.00	00700	OPERATION OF PLANT	1,741,299	2,898,136	4,639,435	4,632,855	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	384,188	495,287	879,475	700,202	8.00
9.00	00900	HOUSEKEEPING	1,539,271	511,525	2,050,796	2,050,796	9.00
10.00	01000	DIETARY	2,441,647	2,623,193	5,064,840	1,804,275	10.00
11.00	01100	CAFETERIA	0	0	0	3,053,518	11.00
13.00	01300	NURSING ADMINISTRATION	984,922	196,878	1,181,800	1,407,259	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	588,753	2,580,614	3,169,367	3,169,367	14.00
15.00	01500	PHARMACY	3,307,575	20,614,225	23,921,800	23,927,222	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,386,388	3,386,388	3,367,340	16.00
17.00	01700	SOCIAL SERVICE	0	2,998,286	2,998,286	2,998,286	17.00
17.01	01701	INSERVICE EDUCATION	645,070	954,318	1,599,388	1,592,903	17.01
23.00	02300	PARAMED PRGM	202,340	38,891	241,231	241,231	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,540,025	6,010,640	17,550,665	17,533,886	30.00
31.00	03100	INTENSIVE CARE UNIT	3,975,605	1,253,045	5,228,650	5,228,650	31.00
40.00	04000	SUBPROVIDER - I PF	3,054,016	416,191	3,470,207	3,470,207	40.00
41.00	04100	SUBPROVIDER - I RF	1,283,822	504,365	1,788,187	1,788,187	41.00
43.00	04300	NURSERY	543,271	105,284	648,555	648,555	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,728,878	36,099,043	37,827,921	26,265,174	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	719,535	199,194	918,729	918,729	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,640,788	7,511,167	13,151,955	12,837,632	54.00
59.00	05900	CARDIAC CATHETERIZATION	1,373,066	8,789,882	10,162,948	5,130,594	59.00
60.00	06000	LABORATORY	3,422,104	7,513,129	10,935,233	10,807,612	60.00
65.00	06500	RESPIRATORY THERAPY	1,521,136	492,285	2,013,421	2,013,421	65.00
66.00	06600	PHYSICAL THERAPY	4,256,547	1,065,754	5,322,301	5,087,072	66.00
69.00	06900	ELECTROCARDIOLOGY	1,047,846	771,336	1,819,182	1,818,978	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	207,829	75,676	283,505	283,326	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	16,486,394	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	756,428	756,428	756,428	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.00
76.01	03952	NEURODIAGNOSTIC	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	196,014	87,549	283,563	245,624	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	4,834,744	6,575,424	11,410,168	11,004,608	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	PATIENT CARE CENTER - OCC	1,458,091	381,944	1,840,035	1,892,331	93.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	722,994	1,470,229	2,193,223	2,152,786	96.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	8,041,854	8,041,854	3,910	113.00
116.00	11600	HOSPICE	1,070,965	731,636	1,802,601	1,802,601	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	70,992,336	181,661,881	252,654,217	273,964,123	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,612	2,922,725	2,925,337	1,665,333	192.00
194.00	07950	RENTAL SPACE	0	17,586,037	17,586,037	2,150,607	194.00
194.01	07951	FOUNDATION	189,369	197,272	386,641	386,641	194.01
194.02	07952	RETAIL SERVICES	83,871	14,710	98,581	98,581	194.02
194.03	07953	REID CONTRACTED SERVICES	353,862	24,070	377,932	557,205	194.03
194.04	07954	REID PHYSICIAN ASSOC.	45,579,739	36,744,649	82,324,388	77,592,013	194.04
194.05	07955	OTHER NON REIMBURSABLE COST CENTERS	0	0	0	36,757	194.05
194.06	07956	VACANT SPACE	0	0	0	0	194.06
194.07	07957	LYNN RHC	75,420	30,328	105,748	85,393	194.07
194.08	07958	CAMBRI DGE RHC	145,189	123,893	269,082	191,310	194.08
200.00		TOTAL (SUM OF LINES 118-199)	117,422,398	239,305,565	356,727,963	356,727,963	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150048

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

Worksheet A
Date/Time Prepared:
5/27/2014 8:01 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-8,051,677	20,114,725	1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE	0	1,260,004	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-6,658,987	16,785,007	4.00
5.01	00510	NONPATIENT TELEPHONES	0	264,465	5.01
5.02	00520	DATA PROCESSING	-3,054,381	15,998,863	5.02
5.03	00530	PURCHASING RECEIVING AND STORES	-476,069	1,081,669	5.03
5.04	00540	ADMINITTING	0	2,094,099	5.04
5.05	00550	CASHIERING/ACCOUNTS RECEIVABLE	-69	3,088,624	5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	-3,514,215	14,399,310	5.06
7.00	00700	OPERATION OF PLANT	-78	4,632,777	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	700,202	8.00
9.00	00900	HOUSEKEEPING	0	2,050,796	9.00
10.00	01000	DIETARY	-728,365	1,075,910	10.00
11.00	01100	CAFETERIA	-2,575,407	478,111	11.00
13.00	01300	NURSING ADMINISTRATION	-105	1,407,154	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-16,395	3,152,972	14.00
15.00	01500	PHARMACY	-164,378	23,762,844	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-80	3,367,260	16.00
17.00	01700	SOCIAL SERVICE	-102,548	2,895,738	17.00
17.01	01701	INSERVICE EDUCATION	-766,672	826,231	17.01
23.00	02300	PARAMED PRGM	-47,825	193,406	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-3,662,567	13,871,319	30.00
31.00	03100	INTENSIVE CARE UNIT	-168	5,228,482	31.00
40.00	04000	SUBPROVIDER - I PF	-32	3,470,175	40.00
41.00	04100	SUBPROVIDER - I RF	-87,671	1,700,516	41.00
43.00	04300	NURSERY	-312	648,243	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-5,199,186	21,065,988	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-65	918,664	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-79,772	12,757,860	54.00
59.00	05900	CARDIAC CATHETERIZATION	-44,740	5,085,854	59.00
60.00	06000	LABORATORY	-838,254	9,969,358	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,013,421	65.00
66.00	06600	PHYSICAL THERAPY	-39,045	5,048,027	66.00
69.00	06900	ELECTROCARDIOLOGY	-62,873	1,756,105	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	283,326	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	16,486,394	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	756,428	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.01	03952	NEURODIAGNOSTIC	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	245,624	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-5,064,830	5,939,778	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	PATIENT CARE CENTER - OCC	0	1,892,331	93.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	-758,817	1,393,969	96.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-3,910	0	113.00
116.00	11600	HOSPICE	-54	1,802,547	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-41,999,547	231,964,576	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,665,333	192.00
194.00	07950	RENTAL SPACE	0	2,150,607	194.00
194.01	07951	FOUNDATION	0	386,641	194.01
194.02	07952	RETAIL SERVICES	0	98,581	194.02
194.03	07953	REID CONTRACTED SERVICES	0	557,205	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	77,592,013	194.04
194.05	07955	OTHER NON REIMBURSABLE COST CENTERS	0	36,757	194.05
194.06	07956	VACANT SPACE	0	0	194.06
194.07	07957	LYNN RHC	0	85,393	194.07
194.08	07958	CAMBRIDGE RHC	0	191,310	194.08
200.00		TOTAL (SUM OF LINES 118-199)	-41,999,547	314,728,416	200.00

RECLASSIFICATIONS

Provider CCN: 150048

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

Worksheet A-6
Date/Time Prepared:
5/27/2014 8:01 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00	3.00	4.00	5.00		
A - ALLOCATION & SUPPORT RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	242,012	1.00
2.00	DATA PROCESSING	5.02	0	270,000	2.00
3.00	PURCHASING RECEIVING AND STORES	5.03	0	84,345	3.00
4.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	971,345	4.00
5.00	PHARMACY	15.00	0	15,167	5.00
	TOTALS		0	1,582,869	
B - CAPITAL EXPENSE RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	14,019,638	1.00
2.00	NEW CAP BLDG & FIXT - OFFSITE	1.01	0	1,095,572	2.00
3.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	25,701	3.00
4.00	NEW CAP BLDG & FIXT - OFFSITE	1.01	0	161,133	4.00
5.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	6,083,119	5.00
6.00	NEW CAP BLDG & FIXT - OFFSITE	1.01	0	3,299	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
	TOTALS		0	21,388,462	
C - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	1,139,980	1,913,538	1.00
	TOTALS		1,139,980	1,913,538	
D - LAUNDRY RECLASS					
1.00	REID CONTRACTED SERVICES	194.03	77,960	101,313	1.00
	TOTALS		77,960	101,313	
E - NURSING VP RECLASS					
1.00	NURSING ADMINISTRATION	13.00	230,504	0	1.00
	TOTALS		230,504	0	
F - QUAKER HILL RECLASS					
1.00	RENTAL SPACE	194.00	0	6,580	1.00
	TOTALS		0	6,580	
G - OCCUPATIONAL MEDICINE RECLASS					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	114,698	254,105	1.00
2.00	OTHER NON REIMBURSABLE COST CENTERS	194.05	25,844	10,913	2.00
	TOTALS		140,542	265,018	
H - IMPLANTABLE DEVICES RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	16,486,394	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	16,486,394	
I - DIETARY COUNSELING RECLASS					
1.00	PATIENT CARE CENTER - OCC	93.00	203,820	0	1.00
	TOTALS		203,820	0	
J - INTEREST RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	8,037,944	1.00
	TOTALS		0	8,037,944	
500.00	Grand Total: Increases		1,792,806	49,782,118	500.00

RECLASSIFICATIONS

Provider CCN: 150048

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

Worksheet A-6

Date/Time Prepared:
5/27/2014 8:01 am

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00			
A - ALLOCATION & SUPPORT RECLASS							
1.00	REID PHYSICIAN ASSOC.	194.04	0	1,484,742	0		1.00
2.00	LYNN RHC	194.07	0	20,355	0		2.00
3.00	CAMBRIDGE RHC	194.08	0	77,772	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	TOTALS		0	1,582,869			
B - CAPITAL EXPENSE RECLASS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6,930	9		1.00
2.00	DATA PROCESSING	5.02	0	12,093	9		2.00
3.00	PURCHASING RECEIVING AND STORES	5.03	0	83,869	13		3.00
4.00	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0	68,966	13		4.00
5.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	190,465	10		5.00
6.00	DIETARY	10.00	0	3,227	10		6.00
7.00	NURSING ADMINISTRATION	13.00	0	5,045	0		7.00
8.00	PHARMACY	15.00	0	9,745	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	19,048	0		9.00
10.00	INSERVICE EDUCATION	17.01	0	6,485	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	16,779	0		11.00
12.00	OPERATING ROOM	50.00	0	308,110	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	114,920	0		13.00
14.00	LABORATORY	60.00	0	127,621	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	235,229	0		15.00
16.00	ELECTROCARDIOLOGY	69.00	0	204	0		16.00
17.00	ELECTROENCEPHALOGRAPHY	70.00	0	179	0		17.00
18.00	CARDIAC REHABILITATION	76.97	0	37,939	0		18.00
19.00	PATIENT CARE CENTER - OCC	93.00	0	151,524	0		19.00
20.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	40,437	0		20.00
21.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,260,004	0		21.00
22.00	RENTAL SPACE	194.00	0	15,442,010	0		22.00
23.00	REID PHYSICIAN ASSOC.	194.04	0	3,247,633	0		23.00
	TOTALS		0	21,388,462			
C - CAFETERIA RECLASS							
1.00	DIETARY	10.00	1,139,980	1,913,538	0		1.00
	TOTALS		1,139,980	1,913,538			
D - LAUNDRY RECLASS							
1.00	LAUNDRY & LINEN SERVICE	8.00	77,960	101,313	0		1.00
	TOTALS		77,960	101,313			
E - NURSING VP RECLASS							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	230,504	0	0		1.00
	TOTALS		230,504	0			
F - QUAKER HILL RECLASS							
1.00	OPERATION OF PLANT	7.00	0	6,580	0		1.00
	TOTALS		0	6,580			
G - OCCUPATIONAL MEDICINE RECLASS							
1.00	EMERGENCY	91.00	140,542	265,018	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		140,542	265,018			
H - IMPLANTABLE DEVICES RECLASS							
1.00	OPERATING ROOM	50.00	0	11,254,637	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	199,403	0		2.00
3.00	CARDIAC CATHETERIZATION	59.00	0	5,032,354	0		3.00
	TOTALS		0	16,486,394			
I - DIETARY COUNSELING RECLASS							
1.00	DIETARY	10.00	203,820	0	0		1.00
	TOTALS		203,820	0			
J - INTEREST RECLASS							
1.00	INTEREST EXPENSE	113.00	0	8,037,944	11		1.00
	TOTALS		0	8,037,944			
500.00	Grand Total: Decreases		1,792,806	49,782,118			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150048

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

Worksheet A-7
Part I
Date/Time Prepared:
5/27/2014 8:01 am

	Beginning Balances	Acquisitions			Disposals and Retirements		
		Purchases	Donation	Total			
	1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	11,622,838	271,300	0	271,300	0	1.00
2.00	Land Improvements	34,340,396	0	0	0	915,708	2.00
3.00	Buildings and Fixtures	117,852,764	104,861,914	0	104,861,914	0	3.00
4.00	Building Improvements	6,675,246	3,265,387	0	3,265,387	0	4.00
5.00	Fixed Equipment	104,378,740	0	0	0	102,295,244	5.00
6.00	Movable Equipment	149,668,818	0	0	0	12,888,275	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	424,538,802	108,398,601	0	108,398,601	116,099,227	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	424,538,802	108,398,601	0	108,398,601	116,099,227	10.00
	Ending Balance		Fully Depreciated Assets				
	6.00		7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	11,894,138	0				1.00
2.00	Land Improvements	33,424,688	0				2.00
3.00	Buildings and Fixtures	222,714,678	0				3.00
4.00	Building Improvements	9,940,633	0				4.00
5.00	Fixed Equipment	2,083,496	0				5.00
6.00	Movable Equipment	136,780,543	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	416,838,176	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	416,838,176	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150048

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

Worksheet A-7
Part II
Date/Time Prepared:
5/27/2014 8:01 am

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150048

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

Worksheet A-7
Part III
Date/Time Prepared:
5/27/2014 8:01 am

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	280,057,633	0	280,057,633	0.671862	0	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	136,780,543	0	136,780,543	0.328138	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	416,838,176	0	416,838,176	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	14,011,240	6,083,119	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0	0	1,095,572	3,299	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	15,106,812	6,086,418	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	-5,335	0	25,701	0	20,114,725	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0	161,133	0	1,260,004	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	-5,335	0	186,834	0	21,374,729	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150048

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

Worksheet A-8

Date/Time Prepared:
5/27/2014 8:01 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst.	A-7 Ref.
			1.00	2.00	3.00	4.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT	1.00		0 1.00
1.01 Investment income - NEW CAP BLDG & FIXT - OFFSITE (chapter 2)			ONEW CAP BLDG & FIXT - OFFSITE	1.01		0 1.01
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW CAP REL COSTS-MVBLE EQUIP	2.00		0 2.00
3.00 Investment income - other (chapter 2)		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	-9,962,439				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	-5,146,643				0 12.00
13.00 Laundry and linen service		0		0.00		0 13.00
14.00 Cafeteria-employees and guests	B	-2,575,407	CAFETERIA	11.00		0 14.00
15.00 Rental of quarters to employee and others		0		0.00		0 15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00		0 16.00
17.00 Sale of drugs to other than patients		0		0.00		0 17.00
18.00 Sale of medical records and abstracts	B	-102,548	SOCIAL SERVICE	17.00		0 18.00
19.00 Nursing school (tuition, fees, books, etc.)	B	-47,750	PARAMED ED PRGM	23.00		0 19.00
20.00 Vending machines	B	-12,000	DIETARY	10.00		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		ORESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			ONEW CAP REL COSTS-BLDG & FIXT	1.00		0 26.00
26.01 Depreciation - NEW CAP BLDG & FIXT - OFFSITE			ONEW CAP BLDG & FIXT - OFFSITE	1.01		0 26.01
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			ONEW CAP REL COSTS-MVBLE EQUIP	2.00		0 27.00
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0	0.00		0 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			OADULTS & PEDIATRICS	30.00		30.99

31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		68.00		31.00			
				Basis/Code (2)	Amount				Cost Center	Line #	Wkst. A-7 Ref.
	CAH HIT Adjustment for Depreciation and Interest		0		*** Cost Center Deleted ***	0.00	0	32.00			
33.00	MI SCCELLANEOUS INCOME	B	-705,987	DIETARY		10.00	0	33.00			
33.01	MI SCCELLANEOUS INCOME	B	-210,752	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.01			
33.02	MI SCCELLANEOUS INCOME	B	-3,054,381	DATA PROCESSING		5.02	0	33.02			
33.03	MI SCCELLANEOUS INCOME	B	-476,069	PURCHASING RECEIVING AND STORES		5.03	0	33.03			
33.04	MI SCCELLANEOUS INCOME	B	-69	CASHIERING/ACCOUNTS RECEIVABLE		5.05	0	33.04			
33.05	MI SCCELLANEOUS INCOME	B	-429,430	OTHER ADMINISTRATIVE AND GENERAL		5.06	0	33.05			
33.06	MI SCCELLANEOUS INCOME	B	-78	OPERATION OF PLANT		7.00	0	33.06			
33.07	MI SCCELLANEOUS INCOME	B	-16,395	CENTRAL SERVICES & SUPPLY		14.00	0	33.07			
33.08	MI SCCELLANEOUS INCOME	B	-164,287	PHARMACY		15.00	0	33.08			
33.09	MI SCCELLANEOUS INCOME	B	-19,003	INSERVICE EDUCATION		17.01	0	33.09			
33.10	MI SCCELLANEOUS INCOME	B	-80	MEDICAL RECORDS & LIBRARY		16.00	0	33.10			
33.11	MI SCCELLANEOUS INCOME	B	-3,075	PHYSICAL THERAPY		66.00	0	33.11			
33.12	MI SCCELLANEOUS INCOME	B	-357	OPERATING ROOM		50.00	0	33.12			
33.13	MI SCCELLANEOUS INCOME	B	-79,772	RADIOLOGY-DIAGNOSTIC		54.00	0	33.13			
33.14	MI SCCELLANEOUS INCOME	B	-44,740	CARDIAC CATHETERIZATION		59.00	0	33.14			
33.15	MI SCCELLANEOUS INCOME	B	-26,970	LABORATORY		60.00	0	33.15			
33.16	MI SCCELLANEOUS INCOME	B	-34,666	PHYSICAL THERAPY		66.00	0	33.16			
33.17	MI SCCELLANEOUS INCOME	B	-1,710	EMERGENCY		91.00	0	33.17			
33.18	MI SCCELLANEOUS INCOME	B	-758,703	DURABLE MEDICAL EQUIP-RENTED		96.00	0	33.18			
33.19	MI SCCELLANEOUS INCOME	B	-3,910	INTEREST EXPENSE		113.00	0	33.19			
33.20	CARRYFORWARD DEPRECIATION	B	3,333	NEW CAP REL COSTS-BLDG & FIXT		1.00	9	33.20			
33.21	PATIENT ENTERTAINMENT SYSTEM	A	-110,226	OTHER ADMINISTRATIVE AND GENERAL		5.06	0	33.21			
33.22	LIFELINE SUPPORT	A	4,845	OTHER ADMINISTRATIVE AND GENERAL		5.06	0	33.22			
33.23	LIFELINE SUPPORT	A	-11,643	NEW CAP REL COSTS-BLDG & FIXT		1.00	9	33.23			
33.24	LIFELINE SUPPORT	A	-88	NEW CAP REL COSTS-BLDG & FIXT		1.00	9	33.24			
33.25	PHYSICIAN MINORITY INTEREST	A	-1,468	DIETARY		10.00	0	33.25			
33.26	COUNTRY CLUB DUES	A	-5,500	OTHER ADMINISTRATIVE AND GENERAL		5.06	0	33.26			
33.27	AHA/IHA LOBBYING	A	-12,478	OTHER ADMINISTRATIVE AND GENERAL		5.06	0	33.27			
33.28	INTEREST INCOME	B	-3,502,848	NEW CAP REL COSTS-BLDG & FIXT		1.00	11	33.28			
33.29	MARKETING/ADVERTISING	A	-40,377	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.29			
33.30	MARKETING/ADVERTISING	A	-2,226,575	OTHER ADMINISTRATIVE AND GENERAL		5.06	0	33.30			
33.31	MARKETING/ADVERTISING	A	-2,849	DIETARY		10.00	0	33.31			
33.32	MARKETING/ADVERTISING	A	-69,582	INSERVICE EDUCATION		17.01	0	33.32			
33.33	MARKETING/ADVERTISING	A	-384	OPERATING ROOM		50.00	0	33.33			
33.34	MARKETING/ADVERTISING	A	-350	PHYSICAL THERAPY		66.00	0	33.34			
33.35	MARKETING/ADVERTISING	A	-100	DURABLE MEDICAL EQUIP-RENTED		96.00	0	33.35			
33.36	NON-ALLOWABLE EXPENSES	A	-10,530	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.36			
33.37	NON-ALLOWABLE EXPENSES	A	-734,851	OTHER ADMINISTRATIVE AND GENERAL		5.06	0	33.37			
33.38	NON-ALLOWABLE EXPENSES	A	-5,679	DIETARY		10.00	0	33.38			
33.39	NON-ALLOWABLE EXPENSES	A	-105	NURSING ADMINISTRATION		13.00	0	33.39			
33.40	NON-ALLOWABLE EXPENSES	A	-91	PHARMACY		15.00	0	33.40			
33.41	NON-ALLOWABLE EXPENSES	A	-447,596	INSERVICE EDUCATION		17.01	0	33.41			
33.42	NON-ALLOWABLE EXPENSES	A	-75	PARAMED PRGM		23.00	0	33.42			
33.43	NON-ALLOWABLE EXPENSES	A	-1,845	ADULTS & PEDIATRICS		30.00	0	33.43			
33.44	NON-ALLOWABLE EXPENSES	A	-168	INTENSIVE CARE UNIT		31.00	0	33.44			
33.45	NON-ALLOWABLE EXPENSES	A	-32	SUBPROVIDER - IPF		40.00	0	33.45			
33.46	NON-ALLOWABLE EXPENSES	A	-3,593	SUBPROVIDER - IRF		41.00	9	33.46			
33.47	NON-ALLOWABLE EXPENSES	A	-312	NURSERY		43.00	0	33.47			
33.48	NON-ALLOWABLE EXPENSES	A	-65	DELIVERY ROOM & LABOR ROOM		52.00	0	33.48			
33.49	NON-ALLOWABLE EXPENSES	A	-954	PHYSICAL THERAPY		66.00	0	33.49			
33.50	NON-ALLOWABLE EXPENSES	A	-2,313	EMERGENCY		91.00	0	33.50			
33.51	NON-ALLOWABLE EXPENSES	A	-14	DURABLE MEDICAL EQUIP-RENTED		96.00	0	33.51			

Provider CCN: 150048

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

Worksheet A-8

Date/Time Prepared:
 5/27/2014 8:01 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
33.52	NON-ALLOWABLE EXPENSES	A	-54	HOSPICE	116.00	0	33.52
33.53	SELF INSURANCE ADJUSTMENT	A	-6,397,328	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.53
33.54	UNNECESSARY BORROWING	A	-4,540,431	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.54
33.55			0		0.00	0	33.55
33.56			0		0.00	0	33.56
33.57			0		0.00	0	33.57
33.58			0		0.00	0	33.58
33.59			0		0.00	0	33.59
33.60			0		0.00	0	33.60
33.61			0		0.00	0	33.61
33.62			0		0.00	0	33.62
33.63			0		0.00	0	33.63
33.64			0		0.00	0	33.64
33.65			0		0.00	0	33.65
33.67			0		0.00	0	33.67
33.68			0		0.00	0	33.68
33.69			0		0.00	0	33.69
33.70			0		0.00	0	33.70
33.71			0		0.00	0	33.71
33.73			0		0.00	0	33.73
33.74			0		0.00	0	33.74
33.75			0		0.00	0	33.75
33.76			0		0.00	0	33.76
33.77			0		0.00	0	33.77
33.78			0		0.00	0	33.78
33.79			0		0.00	0	33.79
33.80			0		0.00	0	33.80
33.81			0		0.00	0	33.81
33.82			0		0.00	0	33.82
33.83			0		0.00	0	33.83
33.84			0		0.00	0	33.84
33.85			0		0.00	0	33.85
33.86			0		0.00	0	33.86
33.87			0		0.00	0	33.87
33.88			0		0.00	0	33.88
33.89			0		0.00	0	33.89
33.90			0		0.00	0	33.90
33.91			0		0.00	0	33.91
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-41,999,547				50.00

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

Provider CCN: 150048

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

Worksheet A-8-1

Date/Time Prepared:
5/27/2014 8:01 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	50.00	OPERATING ROOM	15,753,805	20,900,448	1.00
2.00	0.00		0	0	2.00
3.00	0.00		0	0	3.00
4.00	0.00		0	0	4.00
4.01	0.00		0	0	4.01
4.02	0.00		0	0	4.02
5.00	0	0	15,753,805	20,900,448	5.00

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

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

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

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

6.00	A	REID O/P SURGER	55.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:			0.00	100.00

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

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

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

Provider CCN: 150048

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

Worksheet A-8-1

Date/Time Prepared:
5/27/2014 8:01 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-5,146,643	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
5.00	-5,146,643			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150048

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

Worksheet A-8-2

Date/Time Prepared:
5/27/2014 8:01 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	10.00	DIETARY	382	382	0	0	0	1.00
2.00	17.01	INSERVICE EDUCATION	230,491	230,491	0	0	0	2.00
3.00	41.00	SUBPROVIDER - IRF	84,078	84,078	0	0	0	3.00
4.00	50.00	OPERATING ROOM	51,802	51,802	0	0	0	4.00
5.00	60.00	LABORATORY	811,284	811,284	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	62,873	62,873	0	0	0	6.00
7.00	91.00	EMERGENCY	5,060,807	5,060,807	0	0	0	7.00
8.00	30.00	ADULTS & PEDIATRICS	3,660,722	3,660,722	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			9,962,439	9,962,439	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	10.00	DIETARY	0	0	0	0	0	1.00
2.00	17.01	INSERVICE EDUCATION	0	0	0	0	0	2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	30.00	ADULTS & PEDIATRICS	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	10.00	DIETARY	0	0	0	382	1.00
2.00	17.01	INSERVICE EDUCATION	0	0	0	230,491	2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	84,078	3.00
4.00	50.00	OPERATING ROOM	0	0	0	51,802	4.00
5.00	60.00	LABORATORY	0	0	0	811,284	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	62,873	6.00
7.00	91.00	EMERGENCY	0	0	0	5,060,807	7.00
8.00	30.00	ADULTS & PEDIATRICS	0	0	0	3,660,722	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	9,962,439	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150048

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

Worksheet B
Part I
Date/Time Prepared:
5/27/2014 8:01 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE	NEW MVBLE EQUIP		
	0	1.00	1.01	2.00	4.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	20,114,725	20,114,725			1.00
1.01 00101	NEW CAP BLDG & FIXT - OFFSITE	1,260,004	0	1,260,004		1.01
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	0		0		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	16,785,007	61,036	1,830	0	16,847,873
5.01 00510	NONPATIENT TELEPHONES	264,465	75,535	0	0	35,056
5.02 00520	DATA PROCESSING	15,998,863	270,736	5,009	0	460,714
5.03 00530	PURCHASING RECEIVING AND STORES	1,081,669	311,248	0	0	114,163
5.04 00540	ADMINISTRATIVE	2,094,099	40,333	8,618	0	0
5.05 00550	CASHIERING/ACCOUNTS RECEIVABLE	3,088,624	178,495	37,326	0	0
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	14,399,310	639,262	32,271	0	716,212
7.00 00700	OPERATION OF PLANT	4,632,777	3,705,665	19,020	0	252,649
8.00 00800	LAUNDRY & LINEN SERVICE	700,202	245,319	0	0	44,431
9.00 00900	HOUSEKEEPING	2,050,796	134,762	0	0	223,336
10.00 01000	DIETARY	1,075,910	249,953	0	0	159,289
11.00 01100	CAFETERIA	478,111	196,355	0	0	165,402
13.00 01300	NURSING ADMINISTRATION	1,407,154	38,881	0	0	176,349
14.00 01400	CENTRAL SERVICES & SUPPLY	3,152,972	167,278	0	0	85,423
15.00 01500	PHARMACY	23,762,844	144,606	0	0	479,903
16.00 01600	MEDICAL RECORDS & LIBRARY	3,367,260	186,749	26,910	0	0
17.00 01700	SOCIAL SERVICE	2,895,738	24,681	0	0	0
17.01 01701	INSERVICE EDUCATION	826,231	207,015	0	0	93,594
23.00 02300	PARAMED PRGM	193,406	74,401	12,259	0	29,358
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	13,871,319	2,172,691	0	0	1,674,365
31.00 03100	INTENSIVE CARE UNIT	5,228,482	488,292	0	0	576,828
40.00 04000	SUBPROVIDER - I/PF	3,470,175	444,299	0	0	443,113
41.00 04100	SUBPROVIDER - I/RF	1,700,516	355,957	0	0	186,272
43.00 04300	NURSERY	648,243	53,320	0	0	78,824
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	21,065,988	1,224,249	59,881	0	250,846
52.00 05200	DELIVERY ROOM & LABOR ROOM	918,664	165,389	0	0	104,399
54.00 05400	RADIOLOGY-DIAGNOSTIC	12,757,860	1,240,617	7,319	0	818,433
59.00 05900	CARDIAC CATHETERIZATION	5,085,854	270,060	0	0	199,221
60.00 06000	LABORATORY	9,969,358	277,339	0	0	496,520
65.00 06500	RESPIRATORY THERAPY	2,013,421	32,756	0	0	220,705
66.00 06600	PHYSICAL THERAPY	5,048,027	1,002,358	193,564	0	617,591
69.00 06900	ELECTROCARDIOLOGY	1,756,105	139,435	0	0	152,034
70.00 07000	ELECTROENCEPHALOGRAPHY	283,326	77,404	17,803	0	30,154
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	16,486,394	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00 07400	RENAL DIALYSIS	756,428	29,633	0	0	0
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.01 03952	NEURODIAGNOSTIC	0	0	0	0	0
76.97 07697	CARDIAC REHABILITATION	245,624	89,954	0	0	28,440
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	5,939,778	452,891	0	0	681,091
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00 04040	PATIENT CARE CENTER - OCC	1,892,331	194,545	3,874	0	241,130
OTHER REIMBURSABLE COST CENTERS						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	1,393,969	92,400	13,137	0	104,901
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0
116.00 11600	HOSPICE	1,802,547	8,850	0	0	155,388
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	231,964,576	15,764,749	438,821	0	10,096,134
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	1,665,333	53,797	11,234	0	379
194.00 07950	RENTAL SPACE	2,150,607	378,470	87,048	0	0
194.01 07951	FOUNDATION	386,641	4,097	0	0	27,476
194.02 07952	RETAIL SERVICES	98,581	46,538	0	0	12,169
194.03 07953	REID CONTRACTED SERVICES	557,205	0	0	0	62,654
194.04 07954	REID PHYSICIAN ASSOC.	77,592,013	3,487,511	644,370	0	6,613,302
194.05 07955	OTHER NON REIMBURSABLE COST CENTERS	36,757	10,580	0	0	3,750
194.06 07956	VACANT SPACE	0	368,983	78,531	0	0
194.07 07957	LYNN RHC	85,393	0	0	0	10,943
194.08 07958	CAMBRIDGE RHC	191,310	0	0	0	21,066
200.00	Cross Foot Adjustments					200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150048

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

Worksheet B
Part I
Date/Time Prepared:
5/27/2014 8:01 am

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
			NEW BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE	NEW MVBLE EQUIP		
		0	1.00	1.01	2.00	4.00	
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	314,728,416	20,114,725	1,260,004	0	16,847,873	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150048

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

Worksheet B
Part I
Date/Time Prepared:
5/27/2014 8:01 am

Cost Center Description			NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINISTRATIVE	CASHIERING/ACCOUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00510	NONPATIENT TELEPHONES	375,056					5.01
5.02	00520	DATA PROCESSING	30,818	16,766,140				5.02
5.03	00530	PURCHASING RECEIVING AND STORES	4,092	146,878	1,658,050			5.03
5.04	00540	ADMINISTRATIVE	11,509	257,037	1,772	2,413,368		5.04
5.05	00550	CASHIERING/ACCOUNTS RECEIVABLE	18,030	411,259	2,009	0	3,735,743	5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	15,089	1,167,681	11,128	0	0	5.06
7.00	00700	OPERATION OF PLANT	7,417	337,820	24,305	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	767	14,688	476	0	0	8.00
9.00	00900	HOUSEKEEPING	767	22,032	24,392	0	0	9.00
10.00	01000	DIETARY	11,253	249,693	15,868	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,302	102,815	1,272	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,279	88,127	131,507	0	0	14.00
15.00	01500	PHARMACY	5,499	293,756	124,408	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,695	616,888	3,086	0	0	16.00
17.00	01700	SOCIAL SERVICE	4,348	205,629	5,495	0	0	17.00
17.01	01701	INSERVICE EDUCATION	5,882	1,086,898	2,510	0	0	17.01
23.00	02300	PARAMED PRGM	384	73,439	502	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	29,155	1,747,850	112,366	153,488	237,603	30.00
31.00	03100	INTENSIVE CARE UNIT	6,649	257,037	98,503	42,056	65,104	31.00
40.00	04000	SUBPROVIDER - IPF	2,813	110,159	20,301	40,882	63,287	40.00
41.00	04100	SUBPROVIDER - IRF	4,092	205,629	7,759	12,155	18,816	41.00
43.00	04300	NURSERY	0	0	7,660	7,639	11,825	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	24,168	638,920	285,220	412,126	637,980	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,499	235,005	14,421	20,887	32,334	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,565	1,116,274	202,726	420,702	651,056	54.00
59.00	05900	CARDIAC CATHETERIZATION	3,708	73,439	166,895	204,701	316,881	59.00
60.00	06000	LABORATORY	8,184	425,947	19,172	313,255	484,925	60.00
65.00	06500	RESPIRATORY THERAPY	767	88,127	39,876	42,820	66,286	65.00
66.00	06600	PHYSICAL THERAPY	11,509	763,766	7,983	50,823	78,675	66.00
69.00	06900	ELECTROCARDIOLOGY	1,151	359,851	18,799	90,993	140,858	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	895	58,751	850	10,023	15,515	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,242	1,923	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	104,466	161,715	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	287,392	444,888	73.00
74.00	07400	RENAL DIALYSIS	639	14,688	3,304	3,040	4,706	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03952	NEURODIAGNOSTIC	0	0	0	2	3	76.01
76.97	07697	CARDIAC REHABILITATION	1,534	14,688	1,186	3,884	6,013	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	10,486	550,793	58,991	140,691	217,793	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	PATIENT CARE CENTER - OCC	7,289	286,412	8,612	19,347	29,949	93.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	3,197	88,127	49,923	18,438	28,542	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,662	22,032	43,575	12,316	19,066	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	271,093	12,132,135	1,516,852	2,413,368	3,735,743	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,312	7,344	388	0	0	192.00
194.00	07950	RENTAL SPACE	12,404	0	11,659	0	0	194.00
194.01	07951	FOUNDATION	895	44,063	515	0	0	194.01
194.02	07952	RETAIL SERVICES	0	264,381	197	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	82,352	4,318,217	127,482	0	0	194.04
194.05	07955	OTHER NON REIMBURSABLE COST CENTERS	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.07	07957	LYNN RHC	0	0	308	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	0	649	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	375,056	16,766,140	1,658,050	2,413,368	3,735,743	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150048

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5A.05	5.06	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00520						5.02
5.03	00530						5.03
5.04	00540						5.04
5.05	00550						5.05
5.06	00560	16,980,953	16,980,953				5.06
7.00	00700	8,979,653	512,119	9,491,772			7.00
8.00	00800	1,005,883	57,367	188,759	1,252,009		8.00
9.00	00900	2,456,085	140,073	99,315	0	2,695,473	9.00
10.00	01000	1,761,966	100,487	168,866	0	59,367	10.00
11.00	01100	839,868	47,899	151,084	0	0	11.00
13.00	01300	1,728,773	98,594	29,917	0	123,525	13.00
14.00	01400	3,626,586	206,828	128,711	0	1,711	14.00
15.00	01500	24,811,016	1,414,997	107,731	0	0	15.00
16.00	01600	4,209,588	240,077	17,782	0	14,371	16.00
17.00	01700	3,135,891	178,843	6,703	0	5,817	17.00
17.01	01701	2,222,130	126,730	142,652	0	27,032	17.01
23.00	02300	383,749	21,886	42,955	0	4,277	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	19,998,837	1,140,554	1,654,836	342,290	739,094	30.00
31.00	03100	6,762,951	385,698	375,712	93,479	170,402	31.00
40.00	04000	4,595,029	262,059	341,863	84,486	127,460	40.00
41.00	04100	2,491,196	142,075	273,888	42,674	84,004	41.00
43.00	04300	807,511	46,053	41,027	60,069	9,581	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	24,599,378	1,402,927	621,658	256,456	234,902	50.00
52.00	05200	1,496,598	85,352	127,257	0	54,406	52.00
54.00	05400	17,234,552	982,904	672,095	124,589	135,672	54.00
59.00	05900	6,320,759	360,479	70,285	58,356	26,518	59.00
60.00	06000	11,994,700	684,070	195,492	50	64,842	60.00
65.00	06500	2,504,758	142,849	18,271	0	14,371	65.00
66.00	06600	7,774,296	443,376	737,897	10,768	125,749	66.00
69.00	06900	2,659,226	151,658	8,524	890	35,928	69.00
70.00	07000	494,721	28,214	82,635	4,807	13,858	70.00
71.00	07100	3,165	181	0	0	19,675	71.00
72.00	07200	16,752,575	955,416	0	0	0	72.00
73.00	07300	732,280	41,763	0	0	29,598	73.00
74.00	07400	812,438	46,334	22,801	0	40,205	74.00
76.00	03950	0	0	0	0	0	76.00
76.01	03952	5	0	0	0	0	76.01
76.97	07697	391,323	22,318	0	0	10,265	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	8,052,514	459,243	348,474	168,685	233,876	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	2,683,489	153,042	6,198	4,410	99,573	93.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	1,792,634	102,236	57,416	0	1,711	96.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	2,065,436	117,794	0	0	16,253	116.00
118.00		215,162,512	11,302,495	6,740,804	1,252,009	2,524,043	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	1,746,787	99,621	37,583	0	0	192.00
194.00	07950	2,640,188	150,573	343,087	0	18,820	194.00
194.01	07951	463,687	26,445	3,152	0	3,422	194.01
194.02	07952	421,866	24,059	10,467	0	0	194.02
194.03	07953	619,859	35,351	0	0	0	194.03
194.04	07954	92,865,247	5,296,312	1,986,353	0	149,188	194.04
194.05	07955	51,087	2,914	8,141	0	0	194.05
194.06	07956	447,514	25,522	362,185	0	0	194.06
194.07	07957	96,644	5,512	0	0	0	194.07
194.08	07958	213,025	12,149	0	0	0	194.08
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		314,728,416	16,980,953	9,491,772	1,252,009	2,695,473	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150048

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00520						5.02
5.03	00530						5.03
5.04	00540						5.04
5.05	00550						5.05
5.06	00560						5.06
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	2,090,686					10.00
11.00	01100	0	1,038,851				11.00
13.00	01300	0	7,927	1,988,736			13.00
14.00	01400	0	12,737	0	3,976,573		14.00
15.00	01500	0	34,586	0	0	26,368,330	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
17.01	01701	0	7,468	0	0	0	17.01
23.00	02300	0	1,774	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,229,665	152,185	628,596	350	33,273	30.00
31.00	03100	244,833	43,937	181,480	3,104	9,412	31.00
40.00	04000	415,888	40,877	168,842	0	6,170	40.00
41.00	04100	123,610	14,541	60,063	0	1,707	41.00
43.00	04300	76,690	6,106	25,220	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	57,835	238,884	1,943,505	213,635	50.00
52.00	05200	0	7,639	31,552	1,073	1,628	52.00
54.00	05400	0	61,632	254,570	2,354	486,482	54.00
59.00	05900	0	15,412	63,661	1,427,144	1,582	59.00
60.00	06000	0	48,532	0	300,611	242	60.00
65.00	06500	0	17,238	71,203	91	24,007	65.00
66.00	06600	0	46,394	0	1,009	154	66.00
69.00	06900	0	11,832	0	0	316,827	69.00
70.00	07000	0	2,269	0	0	65	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	21,566,968	73.00
74.00	07400	0	0	0	0	151	74.00
76.00	03950	0	0	0	0	0	76.00
76.01	03952	0	0	0	0	0	76.01
76.97	07697	0	2,403	9,924	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	61,674	254,741	1,920	109,212	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	22,520	0	0	9,610	93.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	0	12,798	0	166,185	0	96.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
116.00	11600	0	11,435	0	537	265,158	116.00
118.00		2,090,686	701,751	1,988,736	3,847,883	23,046,283	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	56	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	2,764	0	0	0	194.01
194.02	07952	0	1,749	0	0	0	194.02
194.03	07953	0	7,209	0	0	0	194.03
194.04	07954	0	323,051	0	128,690	3,314,414	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	959	0	0	211	194.07
194.08	07958	0	1,312	0	0	7,422	194.08
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		2,090,686	1,038,851	1,988,736	3,976,573	26,368,330	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150048

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INSERVICE EDUCATION	PARAMED ED PRGM	Subtotal	
			16.00	17.00	17.01	23.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00510	NONPATIENT TELEPHONES						5.01
5.02	00520	DATA PROCESSING						5.02
5.03	00530	PURCHASING RECEIVING AND STORES						5.03
5.04	00540	ADMITTING						5.04
5.05	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,481,818					16.00
17.00	01700	SOCIAL SERVICE	0	3,327,254				17.00
17.01	01701	INSERVICE EDUCATION	0	0	2,526,012			17.01
23.00	02300	PARAMED ED PRGM	0	0	16,950	471,591		23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	285,044	1,802,446	702,507	0	28,709,677	30.00
31.00	03100	INTENSIVE CARE UNIT	78,102	428,026	204,200	0	8,981,336	31.00
40.00	04000	SUBPROVIDER - IPF	75,923	0	125,984	0	6,244,581	40.00
41.00	04100	SUBPROVIDER - IRF	22,573	0	34,060	0	3,290,391	41.00
43.00	04300	NURSERY	14,186	0	30,606	0	1,117,049	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	765,362	0	41,924	0	30,376,466	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	38,790	17,628	20,298	0	1,882,221	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	781,226	0	107,865	471,591	21,315,532	54.00
59.00	05900	CARDIAC CATHETERIZATION	380,151	0	37,035	0	8,761,382	59.00
60.00	06000	LABORATORY	581,748	0	61,212	0	13,931,499	60.00
65.00	06500	RESPIRATORY THERAPY	79,521	0	43,305	0	2,915,614	65.00
66.00	06600	PHYSICAL THERAPY	94,384	0	91,765	0	9,325,792	66.00
69.00	06900	ELECTROCARDIOLOGY	168,983	0	18,279	0	3,372,147	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	18,613	0	2,657	0	647,839	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,307	0	0	0	25,328	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	194,004	0	0	0	17,901,995	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	533,717	0	0	0	22,904,326	73.00
74.00	07400	RENAL DIALYSIS	5,645	0	3,879	0	931,453	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03952	NEURODIAGNOSTIC	4	0	0	0	9	76.01
76.97	07697	CARDIAC REHABILITATION	7,213	0	3,454	0	446,900	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	261,279	1,079,154	177,207	0	11,207,979	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	PATIENT CARE CENTER - OCC	35,929	0	37,726	0	3,052,497	93.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	34,241	0	12,965	0	2,180,186	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	22,873	0	22,795	0	2,522,281	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,481,818	3,327,254	1,796,673	471,591	202,044,480	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	1,884,047	192.00
194.00	07950	RENTAL SPACE	0	0	0	0	3,152,668	194.00
194.01	07951	FOUNDATION	0	0	3,029	0	502,499	194.01
194.02	07952	RETAIL SERVICES	0	0	3,401	0	461,542	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	662,419	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	523,332	0	104,586,587	194.04
194.05	07955	OTHER NON REIMBURSABLE COST CENTERS	0	0	175,347	0	237,489	194.05
194.06	07956	VACANT SPACE	0	0	0	0	835,221	194.06
194.07	07957	LYNN RHC	0	0	11,212	0	114,538	194.07
194.08	07958	CAMBRIDGE RHC	0	0	13,018	0	246,926	194.08
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,481,818	3,327,254	2,526,012	471,591	314,728,416	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150048

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00510	NONPATIENT TELEPHONES		5.01
5.02	00520	DATA PROCESSING		5.02
5.03	00530	PURCHASING RECEIVING AND STORES		5.03
5.04	00540	ADMITTING		5.04
5.05	00550	CASHIERING/ACCOUNTS RECEIVABLE		5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL		5.06
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
17.01	01701	INSERVICE EDUCATION		17.01
23.00	02300	PARAMED ED PRGM		23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	28,709,677
31.00	03100	INTENSIVE CARE UNIT	0	8,981,336
40.00	04000	SUBPROVIDER - IPF	0	6,244,581
41.00	04100	SUBPROVIDER - IRF	0	3,290,391
43.00	04300	NURSERY	0	1,117,049
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	30,376,466
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,882,221
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,315,532
59.00	05900	CARDIAC CATHETERIZATION	0	8,761,382
60.00	06000	LABORATORY	0	13,931,499
65.00	06500	RESPIRATORY THERAPY	0	2,915,614
66.00	06600	PHYSICAL THERAPY	0	9,325,792
69.00	06900	ELECTROCARDIOLOGY	0	3,372,147
70.00	07000	ELECTROENCEPHALOGRAPHY	0	647,839
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	25,328
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	17,901,995
73.00	07300	DRUGS CHARGED TO PATIENTS	0	22,904,326
74.00	07400	RENAL DIALYSIS	0	931,453
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0
76.01	03952	NEURODIAGNOSTIC	0	9
76.97	07697	CARDIAC REHABILITATION	0	446,900
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	11,207,979
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
93.00	04040	PATIENT CARE CENTER - OCC	0	3,052,497
OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	2,180,186
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE	0	2,522,281
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	202,044,480
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,884,047
194.00	07950	RENTAL SPACE	0	3,152,668
194.01	07951	FOUNDATION	0	502,499
194.02	07952	RETAIL SERVICES	0	461,542
194.03	07953	REID CONTRACTED SERVICES	0	662,419
194.04	07954	REID PHYSICIAN ASSOC.	0	104,586,587
194.05	07955	OTHER NON REIMBURSABLE COST CENTERS	0	237,489
194.06	07956	VACANT SPACE	0	835,221
194.07	07957	LYNN RHC	0	114,538
194.08	07958	CAMBRIDGE RHC	0	246,926
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	314,728,416

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 5/27/2014 8:01 am
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
		NEW BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE	NEW MVBLE EQUIP		
		1.00	1.01	2.00		
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	NEW CAP BLDG & FIXT - OFFSITE					1.01
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	21,264	61,036	1,830	0	84,130 4.00
5.01 00510	NONPATIENT TELEPHONES	3,695	75,535	0	0	79,230 5.01
5.02 00520	DATA PROCESSING	4,665,386	270,736	5,009	0	4,941,131 5.02
5.03 00530	PURCHASING RECEIVING AND STORES	14,733	311,248	0	0	325,981 5.03
5.04 00540	ADMINISTRATIVE	11,556	40,333	8,618	0	60,507 5.04
5.05 00550	CASHIERING/ACCOUNTS RECEIVABLE	23,956	178,495	37,326	0	239,777 5.05
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	170,865	639,262	32,271	0	842,398 5.06
7.00 00700	OPERATION OF PLANT	75,750	3,705,665	19,020	0	3,800,435 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	100,469	245,319	0	0	345,788 8.00
9.00 00900	HOUSEKEEPING	14,713	134,762	0	0	149,475 9.00
10.00 01000	DIETARY	216,432	249,953	0	0	466,385 10.00
11.00 01100	CAFETERIA	0	196,355	0	0	196,355 11.00
13.00 01300	NURSING ADMINISTRATION	4,786	38,881	0	0	43,667 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	152,856	167,278	0	0	320,134 14.00
15.00 01500	PHARMACY	210,481	144,606	0	0	355,087 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	24,393	186,749	26,910	0	238,052 16.00
17.00 01700	SOCIAL SERVICE	6,873	24,681	0	0	31,554 17.00
17.01 01701	INSERVICE EDUCATION	33,517	207,015	0	0	240,532 17.01
23.00 02300	PARAMED PRGM	6,118	74,401	12,259	0	92,778 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	502,976	2,172,691	0	0	2,675,667 30.00
31.00 03100	INTENSIVE CARE UNIT	267,575	488,292	0	0	755,867 31.00
40.00 04000	SUBPROVIDER - I/PF	33,347	444,299	0	0	477,646 40.00
41.00 04100	SUBPROVIDER - I/RF	48,696	355,957	0	0	404,653 41.00
43.00 04300	NURSERY	5,634	53,320	0	0	58,954 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,213,498	1,224,249	59,881	0	2,497,628 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	34,823	165,389	0	0	200,212 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,332,128	1,240,617	7,319	0	3,580,064 54.00
59.00 05900	CARDIAC CATHETERIZATION	681,276	270,060	0	0	951,336 59.00
60.00 06000	LABORATORY	259,039	277,339	0	0	536,378 60.00
65.00 06500	RESPIRATORY THERAPY	55,958	32,756	0	0	88,714 65.00
66.00 06600	PHYSICAL THERAPY	107,724	1,002,358	193,564	0	1,303,646 66.00
69.00 06900	ELECTROCARDIOLOGY	108,753	139,435	0	0	248,188 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	43,705	77,404	17,803	0	138,912 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	4,012	29,633	0	0	33,645 74.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0 76.00
76.01 03952	NEURODIAGNOSTIC	0	0	0	0	0 76.01
76.97 07697	CARDIAC REHABILITATION	22,852	89,954	0	0	112,806 76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	326,753	452,891	0	0	779,644 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
93.00 04040	PATIENT CARE CENTER - OCC	33,413	194,545	3,874	0	231,832 93.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	36,384	92,400	13,137	0	141,921 96.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	827	8,850	0	0	9,677 116.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	11,877,216	15,764,749	438,821	0	28,080,786 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	22,925	53,797	11,234	0	87,956 192.00
194.00 07950	RENTAL SPACE	831,694	378,470	87,048	0	1,297,212 194.00
194.01 07951	FOUNDATION	1,400	4,097	0	0	5,497 194.01
194.02 07952	RETAIL SERVICES	2,296	46,538	0	0	48,834 194.02
194.03 07953	REID CONTRACTED SERVICES	0	0	0	0	0 194.03
194.04 07954	REID PHYSICIAN ASSOC.	1,346,572	3,487,511	644,370	0	5,478,453 194.04
194.05 07955	OTHER NON REIMBURSABLE COST CENTERS	0	10,580	0	0	10,580 194.05
194.06 07956	VACANT SPACE	0	368,983	78,531	0	447,514 194.06
194.07 07957	LYNN RHC	466	0	0	0	466 194.07
194.08 07958	CAMBRI DGE RHC	0	0	0	0	0 194.08
200.00	Cross Foot Adjustments					0 200.00
201.00	Negative Cost Centers					0 201.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150048		Period: From 01/01/2013 To 12/31/2013		Worksheet B Part II Date/Time Prepared: 5/27/2014 8:01 am	
Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
			NEW BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE	NEW MVBLE EQUIP		
202.00	TOTAL (sum lines 118-201)	14,082,569	20,114,725	1,260,004	0	35,457,298	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150048

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

Worksheet B
Part II
Date/Time Prepared:
5/27/2014 8:01 am

Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINISTRATIVE	
			4.00	5.01	5.02	5.03	5.04	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	84,130					4.00
5.01	00510	NONPATIENT TELEPHONES	175	79,405				5.01
5.02	00520	DATA PROCESSING	2,302	6,525	4,949,958			5.02
5.03	00530	PURCHASING RECEIVING AND STORES	570	866	43,364	370,781		5.03
5.04	00540	ADMINISTRATIVE	0	2,437	75,886	396	139,226	5.04
5.05	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	3,817	121,418	449	0	5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	3,579	3,195	344,741	2,489	0	5.06
7.00	00700	OPERATION OF PLANT	1,262	1,570	99,736	5,435	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	222	162	4,336	107	0	8.00
9.00	00900	HOUSEKEEPING	1,116	162	6,505	5,455	0	9.00
10.00	01000	DIETARY	796	2,382	73,718	3,549	0	10.00
11.00	01100	CAFETERIA	826	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	881	487	30,355	284	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	427	271	26,018	29,409	0	14.00
15.00	01500	PHARMACY	2,398	1,164	86,727	27,821	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,841	182,127	690	0	16.00
17.00	01700	SOCIAL SERVICE	0	920	60,709	1,229	0	17.00
17.01	01701	INSERVICE EDUCATION	468	1,245	320,891	561	0	17.01
23.00	02300	PARAMED PRGM	147	81	21,682	112	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,367	6,173	516,027	25,128	8,860	30.00
31.00	03100	INTENSIVE CARE UNIT	2,882	1,408	75,886	22,028	2,428	31.00
40.00	04000	SUBPROVIDER - IPF	2,214	596	32,523	4,540	2,360	40.00
41.00	04100	SUBPROVIDER - IRF	931	866	60,709	1,735	702	41.00
43.00	04300	NURSERY	394	0	0	1,713	441	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,253	5,117	188,632	63,780	23,791	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	522	1,164	69,382	3,225	1,206	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,090	4,142	329,564	45,335	24,194	54.00
59.00	05900	CARDIAC CATHETERIZATION	995	785	21,682	37,322	11,817	59.00
60.00	06000	LABORATORY	2,481	1,733	125,755	4,287	18,083	60.00
65.00	06500	RESPIRATORY THERAPY	1,103	162	26,018	8,917	2,472	65.00
66.00	06600	PHYSICAL THERAPY	3,086	2,437	225,491	1,785	2,934	66.00
69.00	06900	ELECTROCARDIOLOGY	760	244	106,241	4,204	5,253	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	151	190	17,345	190	579	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	72	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	6,031	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	16,590	73.00
74.00	07400	RENAL DIALYSIS	0	135	4,336	739	175	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03952	NEURODIAGNOSTIC	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	142	325	4,336	265	224	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	3,403	2,220	162,614	13,192	8,122	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	PATIENT CARE CENTER - OCC	1,205	1,543	84,559	1,926	1,117	93.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	524	677	26,018	11,164	1,064	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	776	352	6,505	9,745	711	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	50,448	57,394	3,581,836	339,206	139,226	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2	1,760	2,168	87	0	192.00
194.00	07950	RENTAL SPACE	0	2,626	0	2,607	0	194.00
194.01	07951	FOUNDATION	137	190	13,009	115	0	194.01
194.02	07952	RETAIL SERVICES	61	0	78,055	44	0	194.02
194.03	07953	REID CONTRACTED SERVICES	313	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	32,990	17,435	1,274,890	28,508	0	194.04
194.05	07955	OTHER NON REIMBURSABLE COST CENTERS	19	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.07	07957	LYNN RHC	55	0	0	69	0	194.07
194.08	07958	CAMBRIDGE RHC	105	0	0	145	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	84,130	79,405	4,949,958	370,781	139,226	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 150048		Period: From 01/01/2013 To 12/31/2013		Worksheet B Part II Date/Time Prepared: 5/27/2014 8:01 am	
Cost Center Description			CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.05	5.06	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00510	NONPATIENT TELEPHONES						5.01
5.02	00520	DATA PROCESSING						5.02
5.03	00530	PURCHASING RECEIVING AND STORES						5.03
5.04	00540	ADMINITTING						5.04
5.05	00550	CASHIERING/ACCOUNTS RECEIVABLE	365,461					5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	0	1,196,402				5.06
7.00	00700	OPERATION OF PLANT	0	36,080	3,944,518			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,042	78,443	433,100		8.00
9.00	00900	HOUSEKEEPING	0	9,869	41,272	0	213,854	9.00
10.00	01000	DIETARY	0	7,080	70,176	0	4,710	10.00
11.00	01100	CAFETERIA	0	3,375	62,786	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,946	12,433	0	9,800	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,572	53,489	0	136	14.00
15.00	01500	PHARMACY	0	99,691	44,770	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16,914	7,390	0	1,140	16.00
17.00	01700	SOCIAL SERVICE	0	12,600	2,785	0	462	17.00
17.01	01701	INSERVICE EDUCATION	0	8,929	59,282	0	2,145	17.01
23.00	02300	PARAMED ED PRGM	0	1,542	17,851	0	339	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	23,244	80,355	687,704	118,406	58,641	30.00
31.00	03100	INTENSIVE CARE UNIT	6,369	27,174	156,136	32,337	13,519	31.00
40.00	04000	SUBPROVIDER - IPF	6,191	18,463	142,069	29,226	10,112	40.00
41.00	04100	SUBPROVIDER - IRF	1,841	10,010	113,820	14,762	6,665	41.00
43.00	04300	NURSERY	1,157	3,245	17,050	20,779	760	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	62,411	98,840	258,344	88,714	18,637	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,163	6,013	52,885	0	4,316	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	63,698	69,248	279,304	43,098	10,764	54.00
59.00	05900	CARDIAC CATHETERIZATION	30,999	25,397	29,209	20,187	2,104	59.00
60.00	06000	LABORATORY	47,438	48,195	81,241	17	5,144	60.00
65.00	06500	RESPIRATORY THERAPY	6,485	10,064	7,593	0	1,140	65.00
66.00	06600	PHYSICAL THERAPY	7,696	31,237	306,650	3,725	9,977	66.00
69.00	06900	ELECTROCARDIOLOGY	13,780	10,685	3,542	308	2,850	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,518	1,988	34,341	1,663	1,099	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	188	13	0	0	1,561	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	15,820	67,312	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	43,522	2,942	0	0	2,348	73.00
74.00	07400	RENAL DIALYSIS	460	3,264	9,475	0	3,190	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03952	NEURODIAGNOSTIC	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	588	1,572	0	0	814	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	21,306	32,355	144,816	58,352	18,555	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	PATIENT CARE CENTER - OCC	2,930	10,782	2,576	1,526	7,900	93.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	2,792	7,203	23,860	0	136	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,865	8,299	0	0	1,290	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	365,461	796,296	2,801,292	433,100	200,254	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,019	15,619	0	0	192.00
194.00	07950	RENTAL SPACE	0	10,608	142,577	0	1,493	194.00
194.01	07951	FOUNDATION	0	1,863	1,310	0	271	194.01
194.02	07952	RETAIL SERVICES	0	1,695	4,350	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	2,491	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	373,183	825,473	0	11,836	194.04
194.05	07955	OTHER NON REIMBURSABLE COST CENTERS	0	205	3,383	0	0	194.05
194.06	07956	VACANT SPACE	0	1,798	150,514	0	0	194.06
194.07	07957	LYNN RHC	0	388	0	0	0	194.07
194.08	07958	CAMBRIDGE RHC	0	856	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	365,461	1,196,402	3,944,518	433,100	213,854	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150048		Period: From 01/01/2013 To 12/31/2013		Worksheet B Part II Date/Time Prepared: 5/27/2014 8:01 am	
Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	NONPATIENT TELEPHONES					5.01
5.02	00520	DATA PROCESSING					5.02
5.03	00530	PURCHASING RECEIVING AND STORES					5.03
5.04	00540	ADMINISTRATION					5.04
5.05	00550	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL					5.06
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	628,796				10.00
11.00	01100	CAFETERIA	0	263,342			11.00
13.00	01300	NURSING ADMINISTRATION	0	2,009	106,862		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,229	0	447,685	14.00
15.00	01500	PHARMACY	0	8,767	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
17.01	01701	INSERVICE EDUCATION	0	1,893	0	0	17.01
23.00	02300	PARAMED ED PRGM	0	450	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	369,835	38,578	33,779	39	790
31.00	03100	INTENSIVE CARE UNIT	73,636	11,138	9,751	349	224
40.00	04000	SUBPROVIDER - IPF	125,083	10,362	9,072	0	147
41.00	04100	SUBPROVIDER - IRF	37,177	3,686	3,227	0	41
43.00	04300	NURSERY	23,065	1,548	1,355	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	14,661	12,836	218,807	5,075
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,936	1,695	121	39
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,623	13,679	265	11,557
59.00	05900	CARDIAC CATHETERIZATION	0	3,907	3,421	160,665	38
60.00	06000	LABORATORY	0	12,303	0	33,842	6
65.00	06500	RESPIRATORY THERAPY	0	4,370	3,826	10	570
66.00	06600	PHYSICAL THERAPY	0	11,761	0	114	4
69.00	06900	ELECTROCARDIOLOGY	0	2,999	0	0	7,527
70.00	07000	ELECTROENCEPHALOGRAPHY	0	575	0	0	2
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	0	0	0	0	512,360
74.00	07400	RENAL DIALYSIS	0	0	0	0	4
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.01	03952	NEURODIAGNOSTIC	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	609	533	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	15,634	13,688	216	2,594
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04040	PATIENT CARE CENTER - OCC	0	5,709	0	0	228
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	3,244	0	18,709	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	0	2,899	0	60	6,299
118.00		SUBTOTALS (SUM OF LINES 1-117)	628,796	177,890	106,862	433,197	547,505
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	14	0	0	0
194.00	07950	RENTAL SPACE	0	0	0	0	0
194.01	07951	FOUNDATION	0	701	0	0	0
194.02	07952	RETAIL SERVICES	0	443	0	0	0
194.03	07953	REID CONTRACTED SERVICES	0	1,827	0	0	0
194.04	07954	REID PHYSICIAN ASSOC.	0	81,891	0	14,488	78,739
194.05	07955	OTHER NON REIMBURSABLE COST CENTERS	0	0	0	0	0
194.06	07956	VACANT SPACE	0	0	0	0	0
194.07	07957	LYNN RHC	0	243	0	0	5
194.08	07958	CAMBRIDGE RHC	0	333	0	0	176
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	628,796	263,342	106,862	447,685	626,425

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150048		Period: From 01/01/2013 To 12/31/2013		Worksheet B Part II Date/Time Prepared: 5/27/2014 8:01 am	
Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INSERVICE EDUCATION	PARAMED ED PRGM	Subtotal	
		16.00	17.00	17.01	23.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	NONPATIENT TELEPHONES					5.01
5.02	00520	DATA PROCESSING					5.02
5.03	00530	PURCHASING RECEIVING AND STORES					5.03
5.04	00540	ADMITTING					5.04
5.05	00550	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL					5.06
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	448,154				16.00
17.00	01700	SOCIAL SERVICE	0	110,259			17.00
17.01	01701	INSERVICE EDUCATION	0	0	635,946		17.01
23.00	02300	PARAMED ED PRGM	0	0	4,267	139,249	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	28,488	59,730	176,860		4,916,671
31.00	03100	INTENSIVE CARE UNIT	7,806	14,184	51,409		1,264,531
40.00	04000	SUBPROVIDER - IPF	7,588	0	31,718		909,910
41.00	04100	SUBPROVIDER - IRF	2,256	0	8,575		671,656
43.00	04300	NURSERY	1,418	0	7,705		139,584
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	76,494	0	10,555		3,645,575
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,877	584	5,110		355,450
54.00	05400	RADIOLOGY-DIAGNOSTIC	78,301	0	27,156		4,600,082
59.00	05900	CARDIAC CATHETERIZATION	37,994	0	9,324		1,347,182
60.00	06000	LABORATORY	58,142	0	15,411		990,456
65.00	06500	RESPIRATORY THERAPY	7,948	0	10,903		180,295
66.00	06600	PHYSICAL THERAPY	9,433	0	23,103		1,943,079
69.00	06900	ELECTROCARDIOLOGY	16,889	0	4,602		428,072
70.00	07000	ELECTROENCEPHALOGRAPHY	1,860	0	669		201,082
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	231	0	0		2,065
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,390	0	0		108,553
73.00	07300	DRUGS CHARGED TO PATIENTS	53,342	0	0		631,104
74.00	07400	RENAL DIALYSIS	564	0	977		56,964
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		0
76.01	03952	NEURODIAGNOSTIC	0	0	0		0
76.97	07697	CARDIAC REHABILITATION	721	0	870		123,805
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	26,113	35,761	44,613		1,383,198
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
93.00	04040	PATIENT CARE CENTER - OCC	3,591	0	9,498		366,922
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	3,422	0	3,264		243,998
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	2,286	0	5,739		56,503
118.00		SUBTOTALS (SUM OF LINES 1-117)	448,154	110,259	452,328	0	24,566,737
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		114,625
194.00	07950	RENTAL SPACE	0	0	0		1,457,123
194.01	07951	FOUNDATION	0	0	763		23,856
194.02	07952	RETAIL SERVICES	0	0	856		134,338
194.03	07953	REID CONTRACTED SERVICES	0	0	0		4,631
194.04	07954	REID PHYSICIAN ASSOC.	0	0	131,754		8,349,640
194.05	07955	OTHER NON REIMBURSABLE COST CENTERS	0	0	44,145		58,332
194.06	07956	VACANT SPACE	0	0	0		599,826
194.07	07957	LYNN RHC	0	0	2,823		4,049
194.08	07958	CAMBRIDGE RHC	0	0	3,277		4,892
200.00		Cross Foot Adjustments				139,249	139,249
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	448,154	110,259	635,946	139,249	35,457,298

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 5/27/2014 8:01 am
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total		
		25.00	26.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00	
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE		1.01	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00	
5.01	00510	NONPATIENT TELEPHONES		5.01	
5.02	00520	DATA PROCESSING		5.02	
5.03	00530	PURCHASING RECEIVING AND STORES		5.03	
5.04	00540	ADMITTING		5.04	
5.05	00550	CASHIERING/ACCOUNTS RECEIVABLE		5.05	
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL		5.06	
7.00	00700	OPERATION OF PLANT		7.00	
8.00	00800	LAUNDRY & LINEN SERVICE		8.00	
9.00	00900	HOUSEKEEPING		9.00	
10.00	01000	DIETARY		10.00	
11.00	01100	CAFETERIA		11.00	
13.00	01300	NURSING ADMINISTRATION		13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00	
15.00	01500	PHARMACY		15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00	
17.00	01700	SOCIAL SERVICE		17.00	
17.01	01701	INSERVICE EDUCATION		17.01	
23.00	02300	PARAMED ED PRGM		23.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	4,916,671	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,264,531	31.00
40.00	04000	SUBPROVIDER - I PF	0	909,910	40.00
41.00	04100	SUBPROVIDER - I RF	0	671,656	41.00
43.00	04300	NURSERY	0	139,584	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	3,645,575	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	355,450	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,600,082	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,347,182	59.00
60.00	06000	LABORATORY	0	990,456	60.00
65.00	06500	RESPIRATORY THERAPY	0	180,295	65.00
66.00	06600	PHYSICAL THERAPY	0	1,943,079	66.00
69.00	06900	ELECTROCARDIOLOGY	0	428,072	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	201,082	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,065	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	108,553	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	631,104	73.00
74.00	07400	RENAL DIALYSIS	0	56,964	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.01	03952	NEURODIAGNOSTIC	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	123,805	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	1,383,198	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
93.00	04040	PATIENT CARE CENTER - OCC	0	366,922	93.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	243,998	96.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	0	56,503	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	24,566,737	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	114,625	192.00
194.00	07950	RENTAL SPACE	0	1,457,123	194.00
194.01	07951	FOUNDATION	0	23,856	194.01
194.02	07952	RETAIL SERVICES	0	134,338	194.02
194.03	07953	REID CONTRACTED SERVICES	0	4,631	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	8,349,640	194.04
194.05	07955	OTHER NON REIMBURSABLE COST CENTERS	0	58,332	194.05
194.06	07956	VACANT SPACE	0	599,826	194.06
194.07	07957	LYNN RHC	0	4,049	194.07
194.08	07958	CAMBRIDGE RHC	0	4,892	194.08
200.00		Cross Foot Adjustments	0	139,249	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	35,457,298	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150048

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

Worksheet B-1
Date/Time Prepared:
5/27/2014 8:01 am

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (PHONES)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW CAP BLDG & FIXT - OFFSITE (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)			
		1.00	1.01	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,011,397				1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE	0	275,456			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			0		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,069	400	0	116,118,231	4.00
5.01	00510	NONPATIENT TELEPHONES	3,798	0	0	241,609	2,933 5.01
5.02	00520	DATA PROCESSING	13,613	1,095	0	3,175,324	241 5.02
5.03	00530	PURCHASING RECEIVING AND STORES	15,650	0	0	786,830	32 5.03
5.04	00540	ADMINISTRATIVE	2,028	1,884	0	0	90 5.04
5.05	00550	CASHIERING/ACCOUNTS RECEIVABLE	8,975	8,160	0	0	141 5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	32,143	7,055	0	4,936,259	118 5.06
7.00	00700	OPERATION OF PLANT	186,326	4,158	0	1,741,299	58 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,335	0	0	306,228	6 8.00
9.00	00900	HOUSEKEEPING	6,776	0	0	1,539,271	6 9.00
10.00	01000	DIETARY	12,568	0	0	1,097,847	88 10.00
11.00	01100	CAFETERIA	9,873	0	0	1,139,980	0 11.00
13.00	01300	NURSING ADMINISTRATION	1,955	0	0	1,215,426	18 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,411	0	0	588,753	10 14.00
15.00	01500	PHARMACY	7,271	0	0	3,307,575	43 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,390	5,883	0	0	68 16.00
17.00	01700	SOCIAL SERVICE	1,241	0	0	0	34 17.00
17.01	01701	INSERVICE EDUCATION	10,409	0	0	645,070	46 17.01
23.00	02300	PARAMED PRGM	3,741	2,680	0	202,340	3 23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	109,246	0	0	11,540,025	228 30.00
31.00	03100	INTENSIVE CARE UNIT	24,552	0	0	3,975,605	52 31.00
40.00	04000	SUBPROVIDER - I/P	22,340	0	0	3,054,016	22 40.00
41.00	04100	SUBPROVIDER - I/R	17,898	0	0	1,283,822	32 41.00
43.00	04300	NURSERY	2,681	0	0	543,271	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	61,557	13,091	0	1,728,878	189 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,316	0	0	719,535	43 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	62,380	1,600	0	5,640,788	153 54.00
59.00	05900	CARDIAC CATHETERIZATION	13,579	0	0	1,373,066	29 59.00
60.00	06000	LABORATORY	13,945	0	0	3,422,104	64 60.00
65.00	06500	RESPIRATORY THERAPY	1,647	0	0	1,521,136	6 65.00
66.00	06600	PHYSICAL THERAPY	50,400	42,316	0	4,256,547	90 66.00
69.00	06900	ELECTROCARDIOLOGY	7,011	0	0	1,047,846	9 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,892	3,892	0	207,829	7 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	1,490	0	0	0	5 74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0 76.00
76.01	03952	NEURODIAGNOSTIC	0	0	0	0	0 76.01
76.97	07697	CARDIAC REHABILITATION	4,523	0	0	196,014	12 76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	22,772	0	0	4,694,202	82 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04040	PATIENT CARE CENTER - OCC	9,782	847	0	1,661,911	57 93.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	4,646	2,872	0	722,994	25 96.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	445	0	0	1,070,965	13 116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	792,674	95,933	0	69,584,365	2,120 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,705	2,456	0	2,612	65 192.00
194.00	07950	RENTAL SPACE	19,030	19,030	0	0	97 194.00
194.01	07951	FOUNDATION	206	0	0	189,369	7 194.01
194.02	07952	RETAIL SERVICES	2,340	0	0	83,871	0 194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	431,822	0 194.03
194.04	07954	REID PHYSICIAN ASSOC.	175,357	140,869	0	45,579,739	644 194.04
194.05	07955	OTHER NON REIMBURSABLE COST CENTERS	532	0	0	25,844	0 194.05
194.06	07956	VACANT SPACE	18,553	17,168	0	0	0 194.06
194.07	07957	LYNN RHC	0	0	0	75,420	0 194.07
194.08	07958	CAMBRIDGE RHC	0	0	0	145,189	0 194.08
200.00		Cross Foot Adjustments					200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150048

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

Worksheet B-1

Date/Time Prepared:
5/27/2014 8:01 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (PHONES)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW CAP BLDG & FIXT - OFFSITE (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)			
	1.00	1.01	2.00			
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	20,114,725	1,260,004	0	16,847,873	375,056
203.00	Unit cost multiplier (Wkst. B, Part I)	19.888061	4.574248	0.000000	0.145092	127.874531
204.00	Cost to be allocated (per Wkst. B, Part II)				84,130	79,405
205.00	Unit cost multiplier (Wkst. B, Part II)				0.000725	27.072963

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150048

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

Worksheet B-1
Date/Time Prepared:
5/27/2014 8:01 am

Cost Center Description		DATA PROCESSING (TERMINALS)	PURCHASING RECEIVING AND STORES (SUPPLY EXPENSE)	ADMITTING (TOTAL REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (TOTAL REVENUE)	Reconciliation		
		5.02	5.03	5.04	5.05	5A.06		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE					1.01	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	00510	NONPATIENT TELEPHONES					5.01	
5.02	00520	DATA PROCESSING	2,283				5.02	
5.03	00530	PURCHASING RECEIVING AND STORES	20	10,161,299			5.03	
5.04	00540	ADMITTING	35	10,859	624,711,318		5.04	
5.05	00550	CASHIERING/ACCOUNTS RECEIVABLE	56	12,311	0	624,711,318	5.05	
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	159	68,199	0	-16,980,953	5.06	
7.00	00700	OPERATION OF PLANT	46	148,950	0	0	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	2	2,920	0	0	8.00	
9.00	00900	HOUSEKEEPING	3	149,487	0	0	9.00	
10.00	01000	DIETARY	34	97,246	0	0	10.00	
11.00	01100	CAFETERIA	0	0	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	14	7,795	0	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	12	805,938	0	0	14.00	
15.00	01500	PHARMACY	40	762,432	0	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	84	18,912	0	0	16.00	
17.00	01700	SOCIAL SERVICE	28	33,678	0	0	17.00	
17.01	01701	INSERVICE EDUCATION	148	15,381	0	0	17.01	
23.00	02300	PARAMED PRGM	10	3,075	0	0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	238	688,633	39,732,881	39,732,881	30.00	
31.00	03100	INTENSIVE CARE UNIT	35	603,675	10,886,883	10,886,883	31.00	
40.00	04000	SUBPROVIDER - I PF	15	124,416	10,583,043	10,583,043	40.00	
41.00	04100	SUBPROVIDER - I RF	28	47,549	3,146,459	3,146,459	41.00	
43.00	04300	NURSERY	0	46,943	1,977,448	1,977,448	43.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	87	1,747,960	106,685,565	106,685,565	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	32	88,379	5,407,058	5,407,058	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	152	1,242,400	108,877,564	108,877,564	54.00	
59.00	05900	CARDIAC CATHETERIZATION	10	1,022,808	52,990,165	52,990,165	59.00	
60.00	06000	LABORATORY	58	117,494	81,091,169	81,091,169	60.00	
65.00	06500	RESPIRATORY THERAPY	12	244,376	11,084,650	11,084,650	65.00	
66.00	06600	PHYSICAL THERAPY	104	48,926	13,156,343	13,156,343	66.00	
69.00	06900	ELECTROCARDIOLOGY	49	115,207	23,554,908	23,554,908	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	8	5,210	2,594,541	2,594,541	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	321,540	321,540	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	27,042,613	27,042,613	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	74,395,969	74,395,969	73.00	
74.00	07400	RENAL DIALYSIS	2	20,246	786,877	786,877	74.00	
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.00	
76.01	03952	NEURODIAGNOSTIC	0	0	493	493	76.01	
76.97	07697	CARDIAC REHABILITATION	2	7,266	1,005,446	1,005,446	76.97	
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	75	361,526	36,420,256	36,420,256	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00	
93.00	04040	PATIENT CARE CENTER - OCC	39	52,776	5,008,222	5,008,222	93.00	
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	12	305,950	4,772,955	4,772,955	96.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE					113.00	
116.00	11600	HOSPICE	3	267,047	3,188,270	3,188,270	116.00	
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,652	9,295,970	624,711,318	624,711,318	-16,980,953	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1	2,378	0	0	192.00	
194.00	07950	RENTAL SPACE	0	71,453	0	0	194.00	
194.01	07951	FOUNDATION	6	3,159	0	0	194.01	
194.02	07952	RETAIL SERVICES	36	1,206	0	0	194.02	
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	194.03	
194.04	07954	REID PHYSICIAN ASSOC.	588	781,267	0	0	194.04	
194.05	07955	OTHER NON REIMBURSABLE COST CENTERS	0	0	0	0	194.05	
194.06	07956	VACANT SPACE	0	0	0	0	194.06	
194.07	07957	LYNN RHC	0	1,890	0	0	194.07	
194.08	07958	CAMBRIDGE RHC	0	3,976	0	0	194.08	
200.00		Cross Foot Adjustments					200.00	
201.00		Negative Cost Centers					201.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150048

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

Worksheet B-1

Date/Time Prepared:
5/27/2014 8:01 am

Cost Center Description		DATA PROCESSING (TERMINALS)	PURCHASING RECEIVING AND STORES (SUPPLY EXPENSE)	ADMITTING (TOTAL REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (TOTAL REVENUE)	Reconciliation	
		5.02	5.03	5.04	5.05	5A.06	
202.00	Cost to be allocated (per Wkst. B, Part I)	16,766,140	1,658,050	2,413,368	3,735,743		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	7,343.907140	0.163173	0.003863	0.005980		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	4,949,958	370,781	139,226	365,461		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	2,168.181340	0.036490	0.000223	0.000585		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150048

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

Worksheet B-1
Date/Time Prepared:
5/27/2014 8:01 am

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.06	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	NONPATIENT TELEPHONES					5.01
5.02	00520	DATA PROCESSING					5.02
5.03	00530	PURCHASING RECEIVING AND STORES					5.03
5.04	00540	ADMITTING					5.04
5.05	00550	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	297,747,463				5.06
7.00	00700	OPERATION OF PLANT	8,979,653	620,267			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,005,883	12,335	773,337		8.00
9.00	00900	HOUSEKEEPING	2,456,085	6,490	0	15,755	9.00
10.00	01000	DIETARY	1,761,966	11,035	0	347	51,688
11.00	01100	CAFETERIA	839,868	9,873	0	0	0
13.00	01300	NURSING ADMINISTRATION	1,728,773	1,955	0	722	0
14.00	01400	CENTRAL SERVICES & SUPPLY	3,626,586	8,411	0	10	0
15.00	01500	PHARMACY	24,811,016	7,040	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	4,209,588	1,162	0	84	0
17.00	01700	SOCIAL SERVICE	3,135,891	438	0	34	0
17.01	01701	INSERVICE EDUCATION	2,222,130	9,322	0	158	0
23.00	02300	PARAMED PRGM	383,749	2,807	0	25	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	19,998,837	108,140	211,424	4,320	30,401
31.00	03100	INTENSIVE CARE UNIT	6,762,951	24,552	57,740	996	6,053
40.00	04000	SUBPROVIDER - I PF	4,595,029	22,340	52,185	745	10,282
41.00	04100	SUBPROVIDER - I RF	2,491,196	17,898	26,359	491	3,056
43.00	04300	NURSERY	807,511	2,681	37,103	56	1,896
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	24,599,378	40,624	158,407	1,373	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,496,598	8,316	0	318	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,234,552	43,920	76,956	793	0
59.00	05900	CARDIAC CATHETERIZATION	6,320,759	4,593	36,045	155	0
60.00	06000	LABORATORY	11,994,700	12,775	31	379	0
65.00	06500	RESPIRATORY THERAPY	2,504,758	1,194	0	84	0
66.00	06600	PHYSICAL THERAPY	7,774,296	48,220	6,651	735	0
69.00	06900	ELECTROCARDIOLOGY	2,659,226	557	550	210	0
70.00	07000	ELECTROENCEPHALOGRAPHY	494,721	5,400	2,969	81	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,165	0	0	115	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	16,752,575	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	732,280	0	0	173	0
74.00	07400	RENAL DIALYSIS	812,438	1,490	0	235	0
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.01	03952	NEURODIAGNOSTIC	5	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	391,323	0	0	60	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	8,052,514	22,772	104,193	1,367	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
93.00	04040	PATIENT CARE CENTER - OCC	2,683,489	405	2,724	582	0
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,792,634	3,752	0	10	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	2,065,436	0	0	95	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	198,181,559	440,497	773,337	14,753	51,688
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,746,787	2,456	0	0	0
194.00	07950	RENTAL SPACE	2,640,188	22,420	0	110	0
194.01	07951	FOUNDATION	463,687	206	0	20	0
194.02	07952	RETAIL SERVICES	421,866	684	0	0	0
194.03	07953	REID CONTRACTED SERVICES	619,859	0	0	0	0
194.04	07954	REID PHYSICIAN ASSOC.	92,865,247	129,804	0	872	0
194.05	07955	OTHER NON REIMBURSABLE COST CENTERS	51,087	532	0	0	0
194.06	07956	VACANT SPACE	447,514	23,668	0	0	0
194.07	07957	LYNN RHC	96,644	0	0	0	0
194.08	07958	CAMBRI DGE RHC	213,025	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	16,980,953	9,491,772	1,252,009	2,695,473	2,090,686

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150048

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

Worksheet B-1

Date/Time Prepared:
5/27/2014 8:01 am

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.06	7.00	8.00	9.00	10.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	0.057031	15.302720	1.618969	171.086830	40.448189	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,196,402	3,944,518	433,100	213,854	628,796	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.004018	6.359387	0.560040	13.573723	12.165222	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150048

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (MED SUPPLIES)	PHARMACY (DRUGS)	MEDICAL RECORDS & LIBRARY (TOTAL REVENUE)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00520						5.02
5.03	00530						5.03
5.04	00540						5.04
5.05	00550						5.05
5.06	00560						5.06
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	3,336,270					11.00
13.00	01300	25,457	1,546,271				13.00
14.00	01400	40,904	0	18,800,460			14.00
15.00	01500	111,074	0	0	23,521,222		15.00
16.00	01600	0	0	0	0	624,711,318	16.00
17.00	01700	0	0	0	0	0	17.00
17.01	01701	23,982	0	0	0	0	17.01
23.00	02300	5,698	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	488,743	488,743	1,655	29,680	39,732,881	30.00
31.00	03100	141,103	141,103	14,677	8,396	10,886,883	31.00
40.00	04000	131,277	131,277	0	5,504	10,583,043	40.00
41.00	04100	46,700	46,700	0	1,523	3,146,459	41.00
43.00	04300	19,609	19,609	0	0	1,977,448	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	185,736	185,736	9,188,523	190,568	106,685,565	50.00
52.00	05200	24,532	24,532	5,072	1,452	5,407,058	52.00
54.00	05400	197,932	197,932	11,130	433,954	108,877,564	54.00
59.00	05900	49,497	49,497	6,747,248	1,411	52,990,165	59.00
60.00	06000	155,862	0	1,421,226	216	81,091,169	60.00
65.00	06500	55,361	55,361	430	21,415	11,084,650	65.00
66.00	06600	148,994	0	4,770	137	13,156,343	66.00
69.00	06900	37,999	0	0	282,618	23,554,908	69.00
70.00	07000	7,288	0	0	58	2,594,541	70.00
71.00	07100	0	0	0	0	321,540	71.00
72.00	07200	0	0	0	0	27,042,613	72.00
73.00	07300	0	0	0	19,238,284	74,395,969	73.00
74.00	07400	0	0	0	135	786,877	74.00
76.00	03950	0	0	0	0	0	76.00
76.01	03952	0	0	0	0	493	76.01
76.97	07697	7,716	7,716	0	0	1,005,446	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	198,065	198,065	9,079	97,420	36,420,256	91.00
92.00	09200						92.00
93.00	04040	72,323	0	0	8,572	5,008,222	93.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	41,102	0	785,688	0	4,772,955	96.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	36,722	0	2,540	236,528	3,188,270	116.00
118.00		2,253,676	1,546,271	18,192,038	20,557,871	624,711,318	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	180	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	8,876	0	0	0	0	194.01
194.02	07952	5,618	0	0	0	0	194.02
194.03	07953	23,151	0	0	0	0	194.03
194.04	07954	1,037,476	0	608,422	2,956,542	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	3,079	0	0	188	0	194.07
194.08	07958	4,214	0	0	6,621	0	194.08
200.00							200.00
201.00							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150048

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

Worksheet B-1

Date/Time Prepared:
5/27/2014 8:01 am

Cost Center Description		CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (MED SUPPLIES)	PHARMACY (DRUGS)	MEDICAL RECORDS & LIBRARY (TOTAL REVENUE)	
		11.00	13.00	14.00	15.00	16.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	1,038,851	1,988,736	3,976,573	26,368,330	4,481,818	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.311381	1.286150	0.211515	1.121044	0.007174	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	263,342	106,862	447,685	626,425	448,154	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.078933	0.069109	0.023812	0.026632	0.000717	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150048

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

Worksheet B-1
Date/Time Prepared:
5/27/2014 8:01 am

Cost Center Description		SOCIAL SERVICE (TIME SPENT) 17.00	INSERVICE EDUCATION (IN HOUSE ED) 17.01	PARAMED ED PRGM (TIME SPENT) 23.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
1.01	00101				1.01
2.00	00200				2.00
4.00	00400				4.00
5.01	00510				5.01
5.02	00520				5.02
5.03	00530				5.03
5.04	00540				5.04
5.05	00550				5.05
5.06	00560				5.06
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700	6,040			17.00
17.01	01701	0	47,539		17.01
23.00	02300	0	319	100	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	3,272	13,221	0	30.00
31.00	03100	777	3,843	0	31.00
40.00	04000	0	2,371	0	40.00
41.00	04100	0	641	0	41.00
43.00	04300	0	576	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	0	789	0	50.00
52.00	05200	32	382	0	52.00
54.00	05400	0	2,030	100	54.00
59.00	05900	0	697	0	59.00
60.00	06000	0	1,152	0	60.00
65.00	06500	0	815	0	65.00
66.00	06600	0	1,727	0	66.00
69.00	06900	0	344	0	69.00
70.00	07000	0	50	0	70.00
71.00	07100	0	0	0	71.00
72.00	07200	0	0	0	72.00
73.00	07300	0	0	0	73.00
74.00	07400	0	73	0	74.00
76.00	03950	0	0	0	76.00
76.01	03952	0	0	0	76.01
76.97	07697	0	65	0	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	1,959	3,335	0	91.00
92.00	09200				92.00
93.00	04040	0	710	0	93.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	0	244	0	96.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
116.00	11600	0	429	0	116.00
118.00		6,040	33,813	100	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	0	0	0	190.00
192.00	19200	0	0	0	192.00
194.00	07950	0	0	0	194.00
194.01	07951	0	57	0	194.01
194.02	07952	0	64	0	194.02
194.03	07953	0	0	0	194.03
194.04	07954	0	9,849	0	194.04
194.05	07955	0	3,300	0	194.05
194.06	07956	0	0	0	194.06
194.07	07957	0	211	0	194.07
194.08	07958	0	245	0	194.08
200.00					200.00
201.00					201.00
202.00		3,327,254	2,526,012	471,591	202.00
203.00		550.869868	53.135573	4,715.910000	203.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 150048			Period: From 01/01/2013 To 12/31/2013	Worksheet B-1 Date/Time Prepared: 5/27/2014 8:01 am
Cost Center Description		SOCIAL SERVICE (TIME SPENT) 17.00	INSERVICE EDUCATION (IN HOUSE ED) 17.01	PARAMED ED PRGM (TIME SPENT) 23.00		
204.00	Cost to be allocated (per Wkst. B, Part II)	110,259	635,946	139,249		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	18.254801	13.377353	1,392.490000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/27/2014 8:01 am
		Title XVIII	Hospital	PPS

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		28,709,677	0	28,709,677	30.00
31.00	03100 INTENSIVE CARE UNIT		8,981,336	0	8,981,336	31.00
40.00	04000 SUBPROVIDER - I PF		6,244,581	0	6,244,581	40.00
41.00	04100 SUBPROVIDER - I RF		3,290,391	0	3,290,391	41.00
43.00	04300 NURSERY		1,117,049	0	1,117,049	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		30,376,466	0	30,376,466	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		1,882,221	0	1,882,221	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		21,315,532	0	21,315,532	54.00
59.00	05900 CARDIAC CATHETERIZATION		8,761,382	0	8,761,382	59.00
60.00	06000 LABORATORY		13,931,499	0	13,931,499	60.00
65.00	06500 RESPIRATORY THERAPY	0	2,915,614	0	2,915,614	65.00
66.00	06600 PHYSICAL THERAPY	0	9,325,792	0	9,325,792	66.00
69.00	06900 ELECTROCARDIOLOGY		3,372,147	0	3,372,147	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		647,839	0	647,839	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		25,328	0	25,328	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		17,901,995	0	17,901,995	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		22,904,326	0	22,904,326	73.00
74.00	07400 RENAL DIALYSIS		931,453	0	931,453	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS		0	0	0	76.00
76.01	03952 NEURODIAGNOSTIC		9	0	9	76.01
76.97	07697 CARDIAC REHABILITATION		446,900	0	446,900	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY		11,207,979	0	11,207,979	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		2,917,613	0	2,917,613	92.00
93.00	04040 PATIENT CARE CENTER - OCC		3,052,497	0	3,052,497	93.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED		2,180,186	0	2,180,186	96.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
116.00	11600 HOSPICE		2,522,281		2,522,281	116.00
200.00	Subtotal (see instructions)		204,962,093	0	204,962,093	200.00
201.00	Less Observation Beds		2,917,613		2,917,613	201.00
202.00	Total (see instructions)		202,044,480	0	202,044,480	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 150048		Period: From 01/01/2013 To 12/31/2013		Worksheet C Part I Date/Time Prepared: 5/27/2014 8:01 am	
			Title XVIII		Hospital		PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	35,538,056		35,538,056			30.00
31.00	03100	INTENSIVE CARE UNIT	10,886,883		10,886,883			31.00
40.00	04000	SUBPROVIDER - IPF	10,583,043		10,583,043			40.00
41.00	04100	SUBPROVIDER - IRF	3,146,459		3,146,459			41.00
43.00	04300	NURSERY	1,977,448		1,977,448			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	46,450,964	60,234,601	106,685,565	0.284729	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,780,648	626,410	5,407,058	0.348104	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,679,377	85,198,187	108,877,564	0.195775	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	15,225,240	37,764,925	52,990,165	0.165340	0.000000	59.00
60.00	06000	LABORATORY	36,967,069	44,124,100	81,091,169	0.171800	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	9,685,971	1,398,679	11,084,650	0.263032	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,899,334	8,257,009	13,156,343	0.708844	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	4,612,664	18,942,244	23,554,908	0.143161	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,182	2,592,359	2,594,541	0.249693	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	315,748	5,792	321,540	0.078771	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	17,723,729	9,318,884	27,042,613	0.661992	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,782,409	36,613,560	74,395,969	0.307871	0.000000	73.00
74.00	07400	RENAL DIALYSIS	707,554	79,323	786,877	1.183734	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
76.01	03952	NEURODIAGNOSTIC	493	0	493	0.018256	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	1,005,446	1,005,446	0.444479	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	10,445,512	25,974,744	36,420,256	0.307740	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,104,802	3,090,023	4,194,825	0.695527	0.000000	92.00
93.00	04040	PATIENT CARE CENTER - OCC	297	5,007,925	5,008,222	0.609497	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	4,772,955	4,772,955	0.456779	0.000000	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	898,334	2,289,936	3,188,270			116.00
200.00		Subtotal (see instructions)	277,414,216	347,297,102	624,711,318			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	277,414,216	347,297,102	624,711,318			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/27/2014 8:01 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.284729		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.348104		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.195775		54.00
59.00	05900 CARDIAC CATHETERIZATION	0.165340		59.00
60.00	06000 LABORATORY	0.171800		60.00
65.00	06500 RESPIRATORY THERAPY	0.263032		65.00
66.00	06600 PHYSICAL THERAPY	0.708844		66.00
69.00	06900 ELECTROCARDIOLOGY	0.143161		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.249693		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.078771		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.661992		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.307871		73.00
74.00	07400 RENAL DIALYSIS	1.183734		74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
76.01	03952 NEURODIAGNOSTIC	0.018256		76.01
76.97	07697 CARDIAC REHABILITATION	0.444479		76.97
	OUTPATIENT SERVICE COST CENTERS			
91.00	09100 EMERGENCY	0.307740		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.695527		92.00
93.00	04040 PATIENT CARE CENTER - OCC	0.609497		93.00
	OTHER REIMBURSABLE COST CENTERS			
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.456779		96.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/27/2014 8:01 am
		Title XIX	Hospital	Cost

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		28,709,677	0	28,709,677	30.00
31.00	03100 INTENSIVE CARE UNIT		8,981,336	0	8,981,336	31.00
40.00	04000 SUBPROVIDER - I/PF		6,244,581	0	6,244,581	40.00
41.00	04100 SUBPROVIDER - I/RF		3,290,391	0	3,290,391	41.00
43.00	04300 NURSERY		1,117,049	0	1,117,049	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		30,376,466	0	30,376,466	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		1,882,221	0	1,882,221	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		21,315,532	0	21,315,532	54.00
59.00	05900 CARDIAC CATHETERIZATION		8,761,382	0	8,761,382	59.00
60.00	06000 LABORATORY		13,931,499	0	13,931,499	60.00
65.00	06500 RESPIRATORY THERAPY	0	2,915,614	0	2,915,614	65.00
66.00	06600 PHYSICAL THERAPY	0	9,325,792	0	9,325,792	66.00
69.00	06900 ELECTROCARDIOLOGY		3,372,147	0	3,372,147	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		647,839	0	647,839	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		25,328	0	25,328	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		17,901,995	0	17,901,995	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		22,904,326	0	22,904,326	73.00
74.00	07400 RENAL DIALYSIS		931,453	0	931,453	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS		0	0	0	76.00
76.01	03952 NEURODIAGNOSTIC		9	0	9	76.01
76.97	07697 CARDIAC REHABILITATION		446,900	0	446,900	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY		11,207,979	0	11,207,979	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		2,917,613	0	2,917,613	92.00
93.00	04040 PATIENT CARE CENTER - OCC		3,052,497	0	3,052,497	93.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED		2,180,186	0	2,180,186	96.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
116.00	11600 HOSPICE		2,522,281		2,522,281	116.00
200.00	Subtotal (see instructions)		204,962,093	0	204,962,093	200.00
201.00	Less Observation Beds		2,917,613		2,917,613	201.00
202.00	Total (see instructions)		202,044,480	0	202,044,480	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/27/2014 8:01 am
		Title XIX	Hospital	Cost

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	35,538,056		35,538,056		30.00
31.00 03100	INTENSIVE CARE UNIT	10,886,883		10,886,883		31.00
40.00 04000	SUBPROVIDER - IPF	10,583,043		10,583,043		40.00
41.00 04100	SUBPROVIDER - IRF	3,146,459		3,146,459		41.00
43.00 04300	NURSERY	1,977,448		1,977,448		43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	46,450,964	60,234,601	106,685,565	0.284729	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	4,780,648	626,410	5,407,058	0.348104	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	23,679,377	85,198,187	108,877,564	0.195775	54.00
59.00 05900	CARDIAC CATHETERIZATION	15,225,240	37,764,925	52,990,165	0.165340	59.00
60.00 06000	LABORATORY	36,967,069	44,124,100	81,091,169	0.171800	60.00
65.00 06500	RESPIRATORY THERAPY	9,685,971	1,398,679	11,084,650	0.263032	65.00
66.00 06600	PHYSICAL THERAPY	4,899,334	8,257,009	13,156,343	0.708844	66.00
69.00 06900	ELECTROCARDIOLOGY	4,612,664	18,942,244	23,554,908	0.143161	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	2,182	2,592,359	2,594,541	0.249693	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	315,748	5,792	321,540	0.078771	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	17,723,729	9,318,884	27,042,613	0.661992	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	37,782,409	36,613,560	74,395,969	0.307871	73.00
74.00 07400	RENAL DIALYSIS	707,554	79,323	786,877	1.183734	74.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	76.00
76.01 03952	NEURODIAGNOSTIC	493	0	493	0.018256	76.01
76.97 07697	CARDIAC REHABILITATION	0	1,005,446	1,005,446	0.444479	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	10,445,512	25,974,744	36,420,256	0.307740	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,104,802	3,090,023	4,194,825	0.695527	92.00
93.00 04040	PATIENT CARE CENTER - OCC	297	5,007,925	5,008,222	0.609497	93.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	4,772,955	4,772,955	0.456779	96.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	898,334	2,289,936	3,188,270		116.00
200.00	Subtotal (see instructions)	277,414,216	347,297,102	624,711,318		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	277,414,216	347,297,102	624,711,318		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/27/2014 8:01 am
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
76.01	03952 NEURODIAGNOSTIC	0.000000		76.01
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040 PATIENT CARE CENTER - OCC	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150048		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part I Date/Time Prepared: 5/27/2014 8:01 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	4,916,671	0	4,916,671	33,840	145.29	30.00
31.00	INTENSIVE CARE UNIT	1,264,531		1,264,531	6,053	208.91	31.00
40.00	SUBPROVIDER - IPF	909,910	0	909,910	10,282	88.50	40.00
41.00	SUBPROVIDER - IRF	671,656	0	671,656	3,056	219.78	41.00
43.00	NURSERY	139,584		139,584	1,896	73.62	43.00
200.00	Total (lines 30-199)	7,902,352		7,902,352	55,127		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	17,650	2,564,369				
31.00	INTENSIVE CARE UNIT	3,058	638,847				
40.00	SUBPROVIDER - IPF	8,314	735,789				
41.00	SUBPROVIDER - IRF	2,299	505,274				
43.00	NURSERY	0	0				
200.00	Total (lines 30-199)	31,321	4,444,279				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/27/2014 8:01 am
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Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,645,575	106,685,565	0.034171	27,064,508	924,821	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	355,450	5,407,058	0.065738	14,847	976	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,600,082	108,877,564	0.042250	14,167,256	598,567	54.00
59.00	05900	CARDIAC CATHETERIZATION	1,347,182	52,990,165	0.025423	7,803,300	198,383	59.00
60.00	06000	LABORATORY	990,456	81,091,169	0.012214	20,631,652	251,995	60.00
65.00	06500	RESPIRATORY THERAPY	180,295	11,084,650	0.016265	5,903,668	96,023	65.00
66.00	06600	PHYSICAL THERAPY	1,943,079	13,156,343	0.147691	1,718,558	253,816	66.00
69.00	06900	ELECTROCARDIOLOGY	428,072	23,554,908	0.018173	2,857,656	51,932	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	201,082	2,594,541	0.077502	2,182	169	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,065	321,540	0.006422	288	2	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	108,553	27,042,613	0.004014	9,687,289	38,885	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	631,104	74,395,969	0.008483	19,632,769	166,545	73.00
74.00	07400	RENAL DIALYSIS	56,964	786,877	0.072393	531,615	38,485	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.01	03952	NEURODIAGNOSTIC	0	493	0.000000	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	123,805	1,005,446	0.123134	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,383,198	36,420,256	0.037979	5,175,812	196,572	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	499,656	4,194,825	0.119112	594,930	70,863	92.00
93.00	04040	PATIENT CARE CENTER - OCC	366,922	5,008,222	0.073264	297	22	93.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	243,998	4,772,955	0.051121	0	0	96.00
200.00		Total (lines 50-199)	17,107,538	559,391,159		115,786,627	2,888,056	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150048		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part III Date/Time Prepared: 5/27/2014 8:01 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	33,840	0.00	17,650	0		30.00
31.00	03100	INTENSIVE CARE UNIT	6,053	0.00	3,058	0		31.00
40.00	04000	SUBPROVIDER - IPF	10,282	0.00	8,314	0		40.00
41.00	04100	SUBPROVIDER - IRF	3,056	0.00	2,299	0		41.00
43.00	04300	NURSERY	1,896	0.00	0	0		43.00
200.00		Total (lines 30-199)	55,127		31,321	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150048

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

Worksheet D
Part IV
Date/Time Prepared:
5/27/2014 8:01 am

Cost Center Description		Title XVIII				Hospital	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	471,591	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.00
76.01	03952	NEURODIAGNOSTIC	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	PATIENT CARE CENTER - OCC	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
200.00		Total (lines 50-199)	0	0	471,591	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150048

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

Worksheet D
Part IV
Date/Time Prepared:
5/27/2014 8:01 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital			
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	106,685,565	0.000000	0.000000	27,064,508	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,407,058	0.000000	0.000000	14,847	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	471,591	108,877,564	0.004331	0.004331	14,167,256	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	52,990,165	0.000000	0.000000	7,803,300	59.00
60.00	06000	LABORATORY	0	81,091,169	0.000000	0.000000	20,631,652	60.00
65.00	06500	RESPIRATORY THERAPY	0	11,084,650	0.000000	0.000000	5,903,668	65.00
66.00	06600	PHYSICAL THERAPY	0	13,156,343	0.000000	0.000000	1,718,558	66.00
69.00	06900	ELECTROCARDIOLOGY	0	23,554,908	0.000000	0.000000	2,857,656	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,594,541	0.000000	0.000000	2,182	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	321,540	0.000000	0.000000	288	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	27,042,613	0.000000	0.000000	9,687,289	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	74,395,969	0.000000	0.000000	19,632,769	73.00
74.00	07400	RENAL DIALYSIS	0	786,877	0.000000	0.000000	531,615	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.01	03952	NEURODIAGNOSTIC	0	493	0.000000	0.000000	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	1,005,446	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	36,420,256	0.000000	0.000000	5,175,812	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	4,194,825	0.000000	0.000000	594,930	92.00
93.00	04040	PATIENT CARE CENTER - OCC	0	5,008,222	0.000000	0.000000	297	93.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	4,772,955	0.000000	0.000000	0	96.00
200.00		Total (lines 50-199)	471,591	559,391,159			115,786,627	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150048

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

Worksheet D
Part IV
Date/Time Prepared:
5/27/2014 8:01 am

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XVIII Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	21,906,347	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1,289	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	61,358	33,642,438	145,705	54.00
59.00	05900 CARDIAC CATHETERIZATION	0	19,191,252	0	59.00
60.00	06000 LABORATORY	0	2,180,952	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	508,253	0	65.00
66.00	06600 PHYSICAL THERAPY	0	1,480	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	9,910,399	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	1,022,809	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	5,102,012	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	14,335,443	0	73.00
74.00	07400 RENAL DIALYSIS	0	4,169	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.00
76.01	03952 NEURODIAGNOSTIC	0	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0	382,878	0	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0	7,047,189	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,072,925	0	92.00
93.00	04040 PATIENT CARE CENTER - OCC	0	40,783	0	93.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00	Total (lines 50-199)	61,358	116,350,618	145,705	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 8:01 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.284729	21,906,347	0	0	6,237,372	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.348104	1,289	0	0	449	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.195775	33,642,438	0	0	6,586,348	54.00
59.00	05900 CARDIAC CATHETERIZATION	0.165340	19,191,252	0	0	3,173,082	59.00
60.00	06000 LABORATORY	0.171800	2,180,952	27,756	0	374,688	60.00
65.00	06500 RESPIRATORY THERAPY	0.263032	508,253	0	0	133,687	65.00
66.00	06600 PHYSICAL THERAPY	0.708844	1,480	0	0	1,049	66.00
69.00	06900 ELECTROCARDIOLOGY	0.143161	9,910,399	0	0	1,418,783	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.249693	1,022,809	0	0	255,388	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.078771	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.661992	5,102,012	0	0	3,377,491	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.307871	14,335,443	115,689	0	4,413,467	73.00
74.00	07400 RENAL DIALYSIS	1.183734	4,169	0	0	4,935	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.01	03952 NEURODIAGNOSTIC	0.018256	0	0	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.444479	382,878	0	0	170,181	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0.307740	7,047,189	0	0	2,168,702	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.695527	1,072,925	0	0	746,248	92.00
93.00	04040 PATIENT CARE CENTER - OCC	0.609497	40,783	0	0	24,857	93.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.456779	0	0	0	0	96.00
200.00	Subtotal (see instructions)		116,350,618	143,445	0	29,086,727	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		116,350,618	143,445	0	29,086,727	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 8:01 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	4,768	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	35,617	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.01	03952 NEURODIAGNOSTIC	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040 PATIENT CARE CENTER - OCC	0	0	93.00
OTHER REIMBURSABLE COST CENTERS				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00	Subtotal (see instructions)	40,385	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	40,385	0	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150048 Component CCN: 15S048		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part II Date/Time Prepared: 5/27/2014 8:01 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	3,645,575	106,685,565	0.034171	82,149	2,807	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	355,450	5,407,058	0.065738	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,600,082	108,877,564	0.042250	629,312	26,588	54.00
59.00	05900 CARDIAC CATHETERIZATION	1,347,182	52,990,165	0.025423	476	12	59.00
60.00	06000 LABORATORY	990,456	81,091,169	0.012214	1,082,664	13,224	60.00
65.00	06500 RESPIRATORY THERAPY	180,295	11,084,650	0.016265	155,478	2,529	65.00
66.00	06600 PHYSICAL THERAPY	1,943,079	13,156,343	0.147691	248,090	36,641	66.00
69.00	06900 ELECTROCARDIOLOGY	428,072	23,554,908	0.018173	44,573	810	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	201,082	2,594,541	0.077502	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,065	321,540	0.006422	163,380	1,049	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	108,553	27,042,613	0.004014	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	631,104	74,395,969	0.008483	1,537,597	13,043	73.00
74.00	07400 RENAL DIALYSIS	56,964	786,877	0.072393	43,553	3,153	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.01	03952 NEURODIAGNOSTIC	0	493	0.000000	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	123,805	1,005,446	0.123134	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	1,383,198	36,420,256	0.037979	329,544	12,516	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	4,194,825	0.000000	0	0	92.00
93.00	04040 PATIENT CARE CENTER - OCC	366,922	5,008,222	0.073264	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	243,998	4,772,955	0.051121	0	0	96.00
200.00	Total (lines 50-199)	16,607,882	559,391,159		4,316,816	112,372	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150048 Component CCN: 15S048	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/27/2014 8:01 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	471,591	471,591	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.00
76.01	03952	NEURODIAGNOSTIC	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	PATIENT CARE CENTER - OCC	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
200.00		Total (lines 50-199)	0	0	471,591	471,591	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150048 Component CCN: 15S048	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/27/2014 8:01 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	106,685,565	0.000000	0.000000	82,149	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	5,407,058	0.000000	0.000000	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	471,591	108,877,564	0.004331	0.004331	629,312	54.00
59.00	05900 CARDIAC CATHETERIZATION	0	52,990,165	0.000000	0.000000	476	59.00
60.00	06000 LABORATORY	0	81,091,169	0.000000	0.000000	1,082,664	60.00
65.00	06500 RESPIRATORY THERAPY	0	11,084,650	0.000000	0.000000	155,478	65.00
66.00	06600 PHYSICAL THERAPY	0	13,156,343	0.000000	0.000000	248,090	66.00
69.00	06900 ELECTROCARDIOLOGY	0	23,554,908	0.000000	0.000000	44,573	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2,594,541	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	321,540	0.000000	0.000000	163,380	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	27,042,613	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	74,395,969	0.000000	0.000000	1,537,597	73.00
74.00	07400 RENAL DIALYSIS	0	786,877	0.000000	0.000000	43,553	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.01	03952 NEURODIAGNOSTIC	0	493	0.000000	0.000000	0	76.01
76.97	07697 CARDIAC REHABILITATION	0	1,005,446	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0	36,420,256	0.000000	0.000000	329,544	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	4,194,825	0.000000	0.000000	0	92.00
93.00	04040 PATIENT CARE CENTER - OCC	0	5,008,222	0.000000	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	4,772,955	0.000000	0.000000	0	96.00
200.00	Total (lines 50-199)	471,591	559,391,159			4,316,816	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/27/2014 8:01 am
	Component CCN: 15S048	Title XVIII	Subprovider - IPF PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,726	21,487	93	54.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	3,052	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2,052	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.00
76.01 03952 NEURODIAGNOSTIC	0	0	0	76.01
76.97 07697 CARDIAC REHABILITATION	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
91.00 09100 EMERGENCY	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00 04040 PATIENT CARE CENTER - OCC	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS				
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00 Total (lines 50-199)	2,726	26,591	93	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 8:01 am
		Component CCN: 15S048	Title XVIII	Subprovider - IPF
				PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.284729	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.348104	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.195775	21,487	0	4,207	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.165340	0	0	0	59.00
60.00	06000	LABORATORY	0.171800	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.263032	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.708844	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.143161	3,052	0	437	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.249693	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.078771	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.661992	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.307871	2,052	9,561	632	73.00
74.00	07400	RENAL DIALYSIS	1.183734	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	76.00
76.01	03952	NEURODIAGNOSTIC	0.018256	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.444479	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.307740	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.695527	0	0	0	92.00
93.00	04040	PATIENT CARE CENTER - OCC	0.609497	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.456779	0	0	0	96.00
200.00		Subtotal (see instructions)		26,591	9,561	5,276	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		26,591	9,561	5,276	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150048 Component CCN: 15S048	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 8:01 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2,944	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.01 03952 NEURODIAGNOSTIC	0	0	76.01
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS			
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00 04040 PATIENT CARE CENTER - OCC	0	0	93.00
OTHER REIMBURSABLE COST CENTERS			
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00 Subtotal (see instructions)	2,944	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 +/- line 201)	2,944	0	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150048 Component CCN: 15T048		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part II Date/Time Prepared: 5/27/2014 8:01 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	3,645,575	106,685,565	0.034171	6,063	207	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	355,450	5,407,058	0.065738	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,600,082	108,877,564	0.042250	99,676	4,211	54.00
59.00	05900 CARDIAC CATHETERIZATION	1,347,182	52,990,165	0.025423	0	0	59.00
60.00	06000 LABORATORY	990,456	81,091,169	0.012214	247,825	3,027	60.00
65.00	06500 RESPIRATORY THERAPY	180,295	11,084,650	0.016265	63,320	1,030	65.00
66.00	06600 PHYSICAL THERAPY	1,943,079	13,156,343	0.147691	1,464,420	216,282	66.00
69.00	06900 ELECTROCARDIOLOGY	428,072	23,554,908	0.018173	8,029	146	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	201,082	2,594,541	0.077502	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,065	321,540	0.006422	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	108,553	27,042,613	0.004014	7	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	631,104	74,395,969	0.008483	421,515	3,576	73.00
74.00	07400 RENAL DIALYSIS	56,964	786,877	0.072393	20,847	1,509	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.01	03952 NEURODIAGNOSTIC	0	493	0.000000	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	123,805	1,005,446	0.123134	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	1,383,198	36,420,256	0.037979	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	4,194,825	0.000000	0	0	92.00
93.00	04040 PATIENT CARE CENTER - OCC	366,922	5,008,222	0.073264	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	243,998	4,772,955	0.051121	0	0	96.00
200.00	Total (lines 50-199)	16,607,882	559,391,159		2,331,702	229,988	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150048 Component CCN: 15T048	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/27/2014 8:01 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	471,591	471,591	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.00
76.01	03952	NEURODIAGNOSTIC	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	PATIENT CARE CENTER - OCC	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
200.00		Total (lines 50-199)	0	0	471,591	471,591	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150048 Component CCN: 15T048	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/27/2014 8:01 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	106,685,565	0.000000	0.000000	6,063	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	5,407,058	0.000000	0.000000	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	471,591	108,877,564	0.004331	0.004331	99,676	54.00
59.00 05900 CARDIAC CATHETERIZATION	0	52,990,165	0.000000	0.000000	0	59.00
60.00 06000 LABORATORY	0	81,091,169	0.000000	0.000000	247,825	60.00
65.00 06500 RESPIRATORY THERAPY	0	11,084,650	0.000000	0.000000	63,320	65.00
66.00 06600 PHYSICAL THERAPY	0	13,156,343	0.000000	0.000000	1,464,420	66.00
69.00 06900 ELECTROCARDIOLOGY	0	23,554,908	0.000000	0.000000	8,029	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	2,594,541	0.000000	0.000000	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	321,540	0.000000	0.000000	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	27,042,613	0.000000	0.000000	7	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	74,395,969	0.000000	0.000000	421,515	73.00
74.00 07400 RENAL DIALYSIS	0	786,877	0.000000	0.000000	20,847	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.01 03952 NEURODIAGNOSTIC	0	493	0.000000	0.000000	0	76.01
76.97 07697 CARDIAC REHABILITATION	0	1,005,446	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0	36,420,256	0.000000	0.000000	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	4,194,825	0.000000	0.000000	0	92.00
93.00 04040 PATIENT CARE CENTER - OCC	0	5,008,222	0.000000	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	4,772,955	0.000000	0.000000	0	96.00
200.00 Total (lines 50-199)	471,591	559,391,159			2,331,702	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/27/2014 8:01 am
	Component CCN: 15T048	Title XVIII	Subprovider - IRF PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	432	0	0	54.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	167	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.00
76.01 03952 NEURODIAGNOSTIC	0	0	0	76.01
76.97 07697 CARDIAC REHABILITATION	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
91.00 09100 EMERGENCY	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00 04040 PATIENT CARE CENTER - OCC	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS				
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00 Total (lines 50-199)	432	167	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150048 Component CCN: 15T048	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 8:01 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.284729	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.348104	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.195775	0	0	0	0	54.00
59.00 05900 CARDIAC CATHETERIZATION	0.165340	0	0	0	0	59.00
60.00 06000 LABORATORY	0.171800	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.263032	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.708844	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0.143161	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.249693	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.078771	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.661992	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.307871	167	731	0	51	73.00
74.00 07400 RENAL DIALYSIS	1.183734	0	0	0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.01 03952 NEURODIAGNOSTIC	0.018256	0	0	0	0	76.01
76.97 07697 CARDIAC REHABILITATION	0.444479	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0.307740	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.695527	0	0	0	0	92.00
93.00 04040 PATIENT CARE CENTER - OCC	0.609497	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0.456779	0	0	0	0	96.00
200.00	Subtotal (see instructions)		167	731	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)		167	731	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150048 Component CCN: 15T048	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 8:01 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	225	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.01 03952 NEURODIAGNOSTIC	0	0	76.01
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS			
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00 04040 PATIENT CARE CENTER - OCC	0	0	93.00
OTHER REIMBURSABLE COST CENTERS			
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00 Subtotal (see instructions)	225	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 +/- line 201)	225	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150048

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

Worksheet D
Part V
Date/Time Prepared:
5/27/2014 8:01 am

		Title XIX		Hospital		Cost		
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.284729	0	4,292,307	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.348104	0	60,236	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.195775	0	6,433,966	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.165340	0	1,764,885	0	0	59.00
60.00	06000	LABORATORY	0.171800	0	3,045,886	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.263032	0	90,537	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.708844	0	869,051	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.143161	0	876,647	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.249693	0	318,053	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.078771	0	821	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.661992	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.307871	0	2,403,034	0	0	73.00
74.00	07400	RENAL DIALYSIS	1.183734	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.01	03952	NEURODIAGNOSTIC	0.018256	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.444479	0	26,529	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.307740	0	3,033,929	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.695527	0	250,087	0	0	92.00
93.00	04040	PATIENT CARE CENTER - OCC	0.609497	0	160	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.456779	0	0	0	0	96.00
200.00		Subtotal (see instructions)		0	23,466,128	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	23,466,128	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 8:01 am
		Title XIX	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	1,222,144	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	20,968	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,259,610	0	54.00
59.00	05900 CARDIAC CATHETERIZATION	291,806	0	59.00
60.00	06000 LABORATORY	523,283	0	60.00
65.00	06500 RESPIRATORY THERAPY	23,814	0	65.00
66.00	06600 PHYSICAL THERAPY	616,022	0	66.00
69.00	06900 ELECTROCARDIOLOGY	125,502	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	79,416	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	65	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	739,824	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.01	03952 NEURODIAGNOSTIC	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	11,792	0	76.97
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	933,661	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	173,942	0	92.00
93.00	04040 PATIENT CARE CENTER - OCC	98	0	93.00
OTHER REIMBURSABLE COST CENTERS				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00	Subtotal (see instructions)	6,021,947	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	6,021,947	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/27/2014 8:01 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		33,840	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		33,840	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)		30,401	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		17,650	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		28,709,677	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)		28,709,677	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		28,709,677	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		848.39	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		14,974,084	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)		14,974,084	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150048		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/27/2014 8:01 am	
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)	
Title XVIII		1.00	2.00	3.00	4.00	5.00	
Hospital							
PPS							
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	8,981,336	6,053	1,483.78	3,058	4,537,399	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)					33,593,580	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					53,105,063	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)					3,203,216	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,949,414	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					6,152,630	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					46,952,433	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)					3,439	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					848.39	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,917,613	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150048		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/27/2014 8:01 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	4,916,671	28,709,677	0.171255	2,917,613	499,656	90.00
91.00	Nursing School cost	0	28,709,677	0.000000	2,917,613	0	91.00
92.00	Allied health cost	0	28,709,677	0.000000	2,917,613	0	92.00
93.00	All other Medical Education	0	28,709,677	0.000000	2,917,613	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Component CCN: 15S048		Date/Time Prepared: 5/27/2014 8:01 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		10,282	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		10,282	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)		10,282	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		8,314	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,244,581	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)		6,244,581	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		6,244,581	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		607.33	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,049,342	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)		5,049,342	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150048		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
		Component CCN: 15S048				Date/Time Prepared: 5/27/2014 8:01 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	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)					1,195,030		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,244,372		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)					735,789		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					115,098		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					850,887		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					5,393,485		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150048 Component CCN: 15S048		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/27/2014 8:01 am	
		Title XVIII		Subprovider - IPF		PPS	
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	909,910	6,244,581	0.145712	0	0	90.00
91.00	Nursing School cost	0	6,244,581	0.000000	0	0	91.00
92.00	Allied health cost	0	6,244,581	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,244,581	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Component CCN: 15T048		Date/Time Prepared: 5/27/2014 8:01 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,056	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,056	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,056	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,299	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,290,391	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)		3,290,391	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,290,391	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,076.70	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,475,333	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)		2,475,333	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150048		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
		Component CCN: 15T048				Date/Time Prepared: 5/27/2014 8:01 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	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)					1,274,119		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,749,452		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)					505,274		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					230,420		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					735,694		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,013,758		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150048 Component CCN: 15T048		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/27/2014 8:01 am	
		Title XVIII		Subprovider - IRF		PPS	
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	671,656	3,290,391	0.204127	0	0	90.00
91.00	Nursing School cost	0	3,290,391	0.000000	0	0	91.00
92.00	Allied health cost	0	3,290,391	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,290,391	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/27/2014 8:01 am
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		33,840	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		33,840	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)		30,401	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,543	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)		1,896	15.00
16.00	Nursery days (title V or XIX only)		606	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		28,709,677	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)		28,709,677	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		28,709,677	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		848.39	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,309,066	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)		1,309,066	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/27/2014 8:01 am		
Cost Center Description			Title XIX	Hospital	Cost		
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00	NURSERY (title V & XIX only)	1,117,049	1,896	589.16	606	357,031	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	8,981,336	6,053	1,483.78	268	397,653	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							
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,740,781	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,804,531	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)					3,439	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					848.39	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,917,613	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150048		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/27/2014 8:01 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Component CCN: 15S048		Date/Time Prepared: 5/27/2014 8:01 am
		Title XIX	Subprovider - IPF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		10,282	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		10,282	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)		10,282	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		432	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)		1,896	15.00
16.00	Nursery days (title V or XIX only)		606	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,244,581	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)		6,244,581	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		6,244,581	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		607.33	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		262,367	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)		262,367	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150048		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1		
		Component CCN: 15S048				Date/Time Prepared: 5/27/2014 8:01 am		
		Title XIX		Subprovider - IPF		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	0	0	0.00	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)					79,799		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					342,166		49.00
PASS THROUGH COST ADJUSTMENTS								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0		53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges					0		54.00
55.00	Target amount per discharge					0.00		55.00
56.00	Target amount (line 54 x line 55)					0		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00	Bonus payment (see instructions)					0		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00	Relief payment (see instructions)					0		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)					0		87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150048 Component CCN: 15S048		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/27/2014 8:01 am	
		Title XIX		Subprovider - IPF		Cost	
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: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Component CCN: 15T048		Date/Time Prepared: 5/27/2014 8:01 am
		Title XIX	Subprovider - IRF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,056	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,056	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,056	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		11	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)		1,896	15.00
16.00	Nursery days (title V or XIX only)		606	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,290,391	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)		3,290,391	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,290,391	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,076.70	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		11,844	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)		11,844	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150048		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
		Component CCN: 15T048				Date/Time Prepared: 5/27/2014 8:01 am	
		Title XIX		Subprovider - IRF		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	0	0	0.00	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)					15,635		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					27,479		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150048 Component CCN: 15T048		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/27/2014 8:01 am	
		Title XIX		Subprovider - IRF		Cost	
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: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/27/2014 8:01 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		20,461,380		30.00
31.00	03100 INTENSIVE CARE UNIT		5,615,244		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.284729	27,064,508	7,706,050	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.348104	14,847	5,168	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.195775	14,167,256	2,773,595	54.00
59.00	05900 CARDIAC CATHETERIZATION	0.165340	7,803,300	1,290,198	59.00
60.00	06000 LABORATORY	0.171800	20,631,652	3,544,518	60.00
65.00	06500 RESPIRATORY THERAPY	0.263032	5,903,668	1,552,854	65.00
66.00	06600 PHYSICAL THERAPY	0.708844	1,718,558	1,218,190	66.00
69.00	06900 ELECTROCARDIOLOGY	0.143161	2,857,656	409,105	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.249693	2,182	545	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.078771	288	23	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.661992	9,687,289	6,412,908	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.307871	19,632,769	6,044,360	73.00
74.00	07400 RENAL DIALYSIS	1.183734	531,615	629,291	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.01	03952 NEURODIAGNOSTIC	0.018256	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.444479	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.307740	5,175,812	1,592,804	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.695527	594,930	413,790	92.00
93.00	04040 PATIENT CARE CENTER - OCC	0.609497	297	181	93.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.456779	0	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		115,786,627	33,593,580	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		115,786,627		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3	
		Component CCN: 15S048		Date/Time Prepared: 5/27/2014 8:01 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		8,617,721	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.284729	82,149	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.348104	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.195775	629,312	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.165340	476	59.00
60.00	06000	LABORATORY	0.171800	1,082,664	60.00
65.00	06500	RESPIRATORY THERAPY	0.263032	155,478	65.00
66.00	06600	PHYSICAL THERAPY	0.708844	248,090	66.00
69.00	06900	ELECTROCARDIOLOGY	0.143161	44,573	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.249693	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.078771	163,380	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.661992	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.307871	1,537,597	73.00
74.00	07400	RENAL DIALYSIS	1.183734	43,553	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.00
76.01	03952	NEURODIAGNOSTIC	0.018256	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.444479	0	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.307740	329,544	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.695527	0	92.00
93.00	04040	PATIENT CARE CENTER - OCC	0.609497	0	93.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.456779	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		4,316,816	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)		4,316,816	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150048 Component CCN: 15T048	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/27/2014 8:01 am
		Title XVIIII	Subprovider - IRF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		0	40.00
41.00	04100 SUBPROVIDER - IRF		2,367,050	41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.284729	6,063	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.348104	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.195775	99,676	54.00
59.00	05900 CARDIAC CATHETERIZATION	0.165340	0	59.00
60.00	06000 LABORATORY	0.171800	247,825	60.00
65.00	06500 RESPIRATORY THERAPY	0.263032	63,320	65.00
66.00	06600 PHYSICAL THERAPY	0.708844	1,464,420	66.00
69.00	06900 ELECTROCARDIOLOGY	0.143161	8,029	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.249693	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.078771	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.661992	7	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.307871	421,515	73.00
74.00	07400 RENAL DIALYSIS	1.183734	20,847	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.00
76.01	03952 NEURODIAGNOSTIC	0.018256	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.444479	0	76.97
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0.307740	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.695527	0	92.00
93.00	04040 PATIENT CARE CENTER - OCC	0.609497	0	93.00
OTHER REIMBURSABLE COST CENTERS				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.456779	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		2,331,702	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net Charges (line 200 minus line 201)		2,331,702	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/27/2014 8:01 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		2,125,931	30.00
31.00	03100	INTENSIVE CARE UNIT		811,955	31.00
40.00	04000	SUBPROVIDER - IPF		2,059	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		242,158	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.284729	2,290,395	652,142 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.348104	379,410	132,074 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.195775	1,371,410	268,488 54.00
59.00	05900	CARDIAC CATHETERIZATION	0.165340	715,674	118,330 59.00
60.00	06000	LABORATORY	0.171800	2,148,587	369,127 60.00
65.00	06500	RESPIRATORY THERAPY	0.263032	489,507	128,756 65.00
66.00	06600	PHYSICAL THERAPY	0.708844	104,944	74,389 66.00
69.00	06900	ELECTROCARDIOLOGY	0.143161	193,146	27,651 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.249693	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.078771	21,675	1,707 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.661992	40,380	26,731 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.307871	2,201,020	677,630 73.00
74.00	07400	RENAL DIALYSIS	1.183734	15,635	18,508 74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0 76.00
76.01	03952	NEURODIAGNOSTIC	0.018256	0	0 76.01
76.97	07697	CARDIAC REHABILITATION	0.444479	0	0 76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.307740	796,932	245,248 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.695527	0	0 92.00
93.00	04040	PATIENT CARE CENTER - OCC	0.609497	0	0 93.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.456779	0	0 96.00
200.00		Total (sum of lines 50-94 and 96-98)		10,768,715	2,740,781 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		10,768,715	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3	
		Component CCN: 15S048		Date/Time Prepared: 5/27/2014 8:01 am	
		Title XIX	Subprovider - IPF	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	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		453,913	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.284729	2,504	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.348104	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.195775	29,213	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.165340	0	59.00
60.00	06000	LABORATORY	0.171800	64,030	60.00
65.00	06500	RESPIRATORY THERAPY	0.263032	9,924	65.00
66.00	06600	PHYSICAL THERAPY	0.708844	21,222	66.00
69.00	06900	ELECTROCARDIOLOGY	0.143161	739	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.249693	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.078771	1,449	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.661992	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.307871	118,557	73.00
74.00	07400	RENAL DIALYSIS	1.183734	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.00
76.01	03952	NEURODIAGNOSTIC	0.018256	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.444479	0	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.307740	25,977	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.695527	0	92.00
93.00	04040	PATIENT CARE CENTER - OCC	0.609497	0	93.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.456779	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		273,615	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)		273,615	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3	
		Component CCN: 15T048		Date/Time Prepared: 5/27/2014 8:01 am	
		Title XIX	Subprovider - IRF	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	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		29,858	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.284729	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.348104	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.195775	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.165340	0	59.00
60.00	06000	LABORATORY	0.171800	1,951	60.00
65.00	06500	RESPIRATORY THERAPY	0.263032	0	65.00
66.00	06600	PHYSICAL THERAPY	0.708844	20,422	66.00
69.00	06900	ELECTROCARDIOLOGY	0.143161	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.249693	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.078771	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.661992	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.307871	2,678	73.00
74.00	07400	RENAL DIALYSIS	1.183734	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.00
76.01	03952	NEURODIAGNOSTIC	0.018256	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.444479	0	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.307740	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.695527	0	92.00
93.00	04040	PATIENT CARE CENTER - OCC	0.609497	0	93.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.456779	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		25,051	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)		25,051	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/27/2014 8:01 am
		Title XVIII	Hospital	PPS
		0	1.00	2.00
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013 (see instructions)		32,815,316	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		9,789,911	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI (see instructions)		0	1.03
2.00	Outlier payments for discharges. (see instructions)		1,904,185	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		6,400,859	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		155.58	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.36	30.00
31.00	Percentage of Medicaid patient days (see instructions)		16.23	31.00
32.00	Sum of lines 30 and 31		21.59	32.00
33.00	Allowable disproportionate share percentage (see instructions)		7.03	33.00
34.00	Disproportionate share adjustment (see instructions)		2,478,975	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/27/2014 8:01 am	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1	On/After October 1	
			1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)			9,046,380,143	35.00
35.01	Factor 3 (see instructions)			0.000219436	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			1,985,102	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			500,355	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		500,355		36.00
Additional payment for high percentage of ESRD beneficiary discharges					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)			0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)			0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)			0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41)			0	46.00
47.00	Subtotal (see instructions)		47,488,742		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		54,729,278		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		54,729,278		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		3,746,506		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		9,841		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0		55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0		56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).		0		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)		61,358		58.00
59.00	Total (sum of amounts on lines 49 through 58)		58,546,983		59.00
60.00	Primary payer payments		3,181		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		58,543,802		61.00
62.00	Deductibles billed to program beneficiaries		4,302,020		62.00
63.00	Coinurance billed to program beneficiaries		73,683		63.00
64.00	Allowable bad debts (see instructions)		804,182		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		522,718		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		414,523		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		54,690,817		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0		68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS		-29,423		70.00
70.92	Bundled Model 1 discount amount		0		70.92
70.93	HVBP incentive payment (see instructions)		117,274		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		0		70.94
70.95	Recovery of Accelerated Depreciation		0		70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/27/2014 8:01 am	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	On/After October 1 2.00	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		54,778,668		71.00
71.01	Sequestration adjustment (see instructions)		827,158		71.01
72.00	Interim payments		54,849,613		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) line 71 minus lines 71.01, 72 and 73		-898,103		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		342,049		75.00
TO BE COMPLETED BY CONTRACTOR					
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the Time Value of Money		0.00		94.00
95.00	Time Value of Money for operating expenses(see instructions)		0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)		0		96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/27/2014 8:01 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		40,385	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		28,941,022	2.00
3.00	PPS payments		33,482,812	3.00
4.00	Outlier payment (see instructions)		308,545	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.948	5.00
6.00	Line 2 times line 5		27,436,089	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		145,705	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		40,385	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		143,445	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)		143,445	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		143,445	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		103,060	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)		40,385	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)		33,937,062	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		6,795,978	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)		27,181,469	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)		27,181,469	30.00
31.00	Primary payer payments		5,127	31.00
32.00	Subtotal (line 30 minus line 31)		27,176,342	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		1,253,781	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		814,958	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		766,022	36.00
37.00	Subtotal (see instructions)		27,991,300	37.00
38.00	MSP-LCC reconciliation amount from PS&R		741	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)		27,990,559	40.00
40.01	Sequestration adjustment (see instructions)		422,657	40.01
41.00	Interim payments		27,219,965	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		347,937	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/27/2014 8:01 am
		Component CCN: 15S048	Title XVII I	Subprovider - IPF
		PPS		
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,944	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		5,183	2.00
3.00	PPS payments		7,094	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		93	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		2,944	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		9,561	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)		9,561	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		9,561	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		6,617	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		2,944	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)		7,187	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,352	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)		8,779	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)		8,779	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		8,779	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		8,779	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)		8,779	40.00
40.01	Sequestration adjustment (see instructions)		133	40.01
41.00	Interim payments		7,559	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		1,087	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/27/2014 8:01 am
		Component CCN: 15T048	Title XVII I	Subprovider - IRF PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		225	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		51	2.00
3.00	PPS payments		194	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)		225	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		731	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)		731	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		731	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		506	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)		225	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)		194	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		0	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)		419	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)		419	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		419	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		419	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)		419	40.00
40.01	Sequestration adjustment (see instructions)		6	40.01
41.00	Interim payments		335	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		78	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150048

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

Worksheet E-1
Part I
Date/Time Prepared:
5/27/2014 8:01 am

Title XVIII

Hospital

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		54,804,413		27,219,965	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	07/18/2013	45,200		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
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)		45,200		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		54,849,613		27,219,965	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		347,937	6.01
6.02	SETTLEMENT TO PROGRAM		898,103		0	6.02
7.00	Total Medicare program liability (see instructions)		53,951,510		27,567,902	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: 150048
Component CCN: 15S048

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

Worksheet E-1
Part I
Date/Time Prepared:
5/27/2014 8:01 am

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					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		7,081,181		7,559	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		7,081,181		7,559	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		1,087	6.01
6.02	SETTLEMENT TO PROGRAM		3,856		0	6.02
7.00	Total Medicare program liability (see instructions)		7,077,325		8,646	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: 150048
Component CCN: 15T048

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

Worksheet E-1
Part I
Date/Time Prepared:
5/27/2014 8:01 am
PPS

Title XVIII

Subprovider -
IRF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
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		3,661,194		335	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,661,194		335	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		78	6.01
6.02	SETTLEMENT TO PROGRAM		17,290		0	6.02
7.00	Total Medicare program liability (see instructions)		3,643,904		413	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: 150048

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

Worksheet E-1
Part II
Date/Time Prepared:
5/27/2014 8:01 am

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	10,565	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	20,708	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2	3,028	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	36,454	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	624,711,318	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	24,937,530	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	2,633,586	8.00
9.00	Sequestration adjustment amount (see instructions)	52,672	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	2,580,914	10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30.00	Initial/interim HIT payment adjustment (see instructions)	2,482,554	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)	98,360	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part II Date/Time Prepared: 5/27/2014 8:01 am
		Component CCN: 15S048	Title XVII	Subprovider - IPF
		PPS		
		1.00		
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		7,746,504	1.00
2.00	Net IPF PPS Outlier Payments		42,384	2.00
3.00	Net IPF PPS ECT Payments		1,634	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program". (see inst.)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program". (see inst.)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		28.169863	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line } 8/\text{line } 9))) \text{ raised to the power of } .5150 - 1\}$.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		7,790,522	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			14.00
15.00	Cost of teaching physicians (From Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	15.00
16.00	Subtotal (see instructions)		7,790,522	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		7,790,522	18.00
19.00	Deductibles		331,184	19.00
20.00	Subtotal (line 18 minus line 19)		7,459,338	20.00
21.00	Coinsurance		275,974	21.00
22.00	Subtotal (line 20 minus line 21)		7,183,364	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	25.00
26.00	Subtotal (sum of lines 22 and 24)		7,183,364	26.00
27.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	27.00
28.00	Other pass through costs (see instructions)		2,726	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS		-259	30.00
30.99	Recovery of Accelerated Depreciation		0	30.99
31.00	Total amount payable to the provider (see instructions)		7,185,831	31.00
31.01	Sequestration adjustment (see instructions)		108,506	31.01
32.00	Interim payments		7,081,181	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33		-3,856	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		42,384	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part III Date/Time Prepared: 5/27/2014 8:01 am
		Component CCN: 15T048		
		Title XVIIII	Subprovider - IRF	PPS
			Prior to 10/01	On/After 10/01
			1.00	1.01
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)		2,572,385	538,474
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0239	
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		43,731	6,300
4.00	Outlier Payments		559,355	
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)		0.00	
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	
6.00	New Teaching program adjustment. (see instructions)		0.00	
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program". (see inst.)		0.00	
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program". (see inst.)		0.00	
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)		0.00	
10.00	Average Daily Census (see instructions)		8.372603	
11.00	Teaching Adjustment Factor (see instructions)		0.000000	0.000000
12.00	Teaching Adjustment (see instructions)		0	0
13.00	Total PPS Payment (see instructions)		3,720,245	
14.00	Nursing and Allied Health Managed Care payments (see instruction)		0	
15.00	Organ acquisition (DO NOT USE THIS LINE)			
16.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	
17.00	Subtotal (see instructions)		3,720,245	
18.00	Primary payer payments		0	
19.00	Subtotal (line 17 less line 18).		3,720,245	
20.00	Deductibles		14,208	
21.00	Subtotal (line 19 minus line 20)		3,706,037	
22.00	Coinurance		592	
23.00	Subtotal (line 21 minus line 22)		3,705,445	
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	
25.00	Adjusted reimbursable bad debts (see instructions)		0	
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	
27.00	Subtotal (sum of lines 23 and 25)		3,705,445	
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	
29.00	Other pass through costs (see instructions)		432	
30.00	Outlier payments reconciliation		0	
31.00	OTHER ADJUSTMENTS		-6,106	
31.99	Recovery of Accelerated Depreciation		0	
32.00	Total amount payable to the provider (see instructions)		3,699,771	
32.01	Sequestration adjustment (see instructions)		55,867	
33.00	Interim payments		3,661,194	
34.00	Tentative settlement (for contractor use only)		0	
35.00	Balance due provider/program line 32 minus lines 32.01, 33 and 34		-17,290	
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4		559,355	
51.00	Outlier reconciliation adjustment amount (see instructions)		0	
52.00	The rate used to calculate the Time Value of Money		0.00	
53.00	Time Value of Money (see instructions)		0	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part VII Date/Time Prepared: 5/27/2014 8:01 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		4,804,531		1.00
2.00	Medical and other services			6,021,947	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		4,804,531	6,021,947	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)		4,804,531	6,021,947	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		10,768,715	23,466,128	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)		10,768,715	23,466,128	12.00
CUSTOMARY CHARGES					
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)		10,768,715	23,466,128	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		5,964,184	17,444,181	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)		4,804,531	6,021,947	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
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		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		4,804,531	6,021,947	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
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)		4,804,531	6,021,947	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)		4,804,531	6,021,947	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		4,804,531	6,021,947	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)		4,804,531	6,021,947	40.00
41.00	Interim payments		4,804,531	6,021,947	41.00
42.00	Balance due provider/program (line 40 minus 41)		0	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150048 Component CCN: 15S048	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part VII Date/Time Prepared: 5/27/2014 8:01 am
		Title XIX	Subprovider - IPF	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	342,166		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)	342,166	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)	342,166	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	273,615	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)	273,615	0	12.00
CUSTOMARY CHARGES				
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)	273,615	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	68,551	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)	273,615	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	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)	273,615	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	68,551	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	273,615	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	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	273,615	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	273,615	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	273,615	0	40.00
41.00	Interim payments	273,615	0	41.00
42.00	Balance due provider/program (line 40 minus 41)	0	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150048 Component CCN: 15T048	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part VII Date/Time Prepared: 5/27/2014 8:01 am
		Title XIX	Subprovider - IRF	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	27,479		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)	27,479	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)	27,479	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	25,051	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)	25,051	0	12.00
CUSTOMARY CHARGES				
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)	25,051	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	2,428	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)	25,051	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	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)	25,051	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	2,428	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	25,051	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	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	25,051	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	25,051	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	25,051	0	40.00
41.00	Interim payments	25,051	0	41.00
42.00	Balance due provider/program (line 40 minus 41)	0	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: 150048

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

Worksheet G
Date/Time Prepared:
5/27/2014 8:01 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	9,519,840	0	0	0	1.00
2.00	Temporary investments	240,306,254	0	0	0	2.00
3.00	Notes receivable	25,496,035	0	0	0	3.00
4.00	Accounts receivable	127,021,760	0	0	0	4.00
5.00	Other receivable	-50,120	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-70,327,113	0	0	0	6.00
7.00	Inventory	3,189,303	0	0	0	7.00
8.00	Prepaid expenses	3,974,706	0	0	0	8.00
9.00	Other current assets	6,704,459	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)	345,835,124	0	0	0	11.00
FIXED ASSETS						
12.00	Land	11,894,138	0	0	0	12.00
13.00	Land improvements	33,424,688	0	0	0	13.00
14.00	Accumulated depreciation	-12,638,893	0	0	0	14.00
15.00	Buildings	222,714,678	0	0	0	15.00
16.00	Accumulated depreciation	-66,196,387	0	0	0	16.00
17.00	Leasehold improvements	9,940,633	0	0	0	17.00
18.00	Accumulated depreciation	-3,020,291	0	0	0	18.00
19.00	Fixed equipment	2,083,496	0	0	0	19.00
20.00	Accumulated depreciation	-886,420	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	136,780,543	0	0	0	23.00
24.00	Accumulated depreciation	-110,003,519	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)	224,092,666	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	24,366,222	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	24,366,222	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	594,294,012	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	14,034,689	0	0	0	37.00
38.00	Salaries, wages, and fees payable	31,409,487	0	0	0	38.00
39.00	Payroll taxes payable	261,062	0	0	0	39.00
40.00	Notes and loans payable (short term)	3,255,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	2,735,379	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	51,695,617	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	170,480,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	-3,255,415	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	167,224,585	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	218,920,202	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	375,373,810				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	375,373,810	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	594,294,012	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150048

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

Worksheet G-1

Date/Time Prepared:
5/27/2014 8:01 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		341,998,729		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		33,375,081			2.00
3.00	Total (sum of line 1 and line 2)		375,373,810		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)		375,373,810		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		375,373,810		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150048

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/27/2014 8:01 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	40,131,286		40,131,286	1.00
2.00	SUBPROVIDER - IPF	10,649,703		10,649,703	2.00
3.00	SUBPROVIDER - IRF	3,146,459		3,146,459	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	53,927,448		53,927,448	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	11,024,184		11,024,184	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)	11,024,184		11,024,184	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	64,951,632		64,951,632	17.00
18.00	Ancillary services	206,379,960	316,476,963	522,856,923	18.00
19.00	Outpatient services	12,607,471	40,158,550	52,766,021	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
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	898,334	2,289,936	3,188,270	26.00
27.00	OTHER	26,663,955	87,964,221	114,628,176	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	311,501,352	446,889,670	758,391,022	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		356,727,963		29.00
30.00	ADD	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	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)		356,727,963		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150048

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

Worksheet G-3

Date/Time Prepared:
5/27/2014 8:01 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	758,391,022	1.00
2.00	Less contractual allowances and discounts on patients' accounts	430,889,605	2.00
3.00	Net patient revenues (line 1 minus line 2)	327,501,417	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	356,727,963	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-29,226,546	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	666,701	6.00
7.00	Income from investments	48,245,225	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	661,747	10.00
11.00	Rebates and refunds of expenses	17,196	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	302,298	13.00
14.00	Revenue from meals sold to employees and guests	3,059,870	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	87,304	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	47,750	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	12,000	21.00
22.00	Rental of hospital space	2,563,874	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER	6,937,662	24.00
25.00	Total other income (sum of lines 6-24)	62,601,627	25.00
26.00	Total (line 5 plus line 25)	33,375,081	26.00
27.00	OTHER EXPENSES	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	33,375,081	29.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet I-5 Date/Time Prepared: 5/27/2014 8:01 am
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		1.00	2.00	
PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B				
1.00	Total expenses related to care of program beneficiaries (see instructions)	0		1.00
2.00	Total payment due (from Wkst. 1-4, col. 6, line 11) (see instructions)	0	0	2.00
2.01	Total payment due (from Wkst. 1-4, col. 6.01, line 11) (see instructions)			2.01
2.02	Total payment due (from Wkst. 1-4, col. 6.02, line 11) (see instructions)	0	0	2.02
2.03	Total payment due (see instructions)	0	0	2.03
2.04	Outlier payments	0		2.04
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.00
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)			3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.03
4.00	Coinsurance billed to Medicare (Part B) patients	0	0	4.00
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	4.03
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	0	0	5.00
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012	0	0	5.01
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013	0	0	5.02
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014	0	0	5.03
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014			5.04
5.05	Total bad debts (sum of line 5 through line 5.04)	0	0	5.05
6.00	Allowable bad debts (see instructions)	0		6.00
7.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0		7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	8.00
9.00	Program payment (see instructions)	0	0	9.00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)			10.00
11.00	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)	0		11.00
PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE				
12.00	Total allowable expenses (see instructions)	0		12.00
13.00	Total composite costs (from Wkst. 1-4, col. 2, line 11)	0		13.00
14.00	Facility specific composite cost percentage (line 13 divided by line 12)	0.000000		14.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150048

Period: From 01/01/2013

Worksheet K

Hospice CCN: 151524

To 12/31/2013

Date/Time Prepared: 5/27/2014 8:01 am

		Hospice I					
		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		420	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	129,017	62,862	58,110	0	352,167	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	217,056	15,194	0	0	3,811	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	615,778	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	86,396	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	22,718	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	236,528	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	4	24.00
25.00	Other - Specify	0	0	0	0	2,540	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	1,070,965	78,056	58,110	0	595,470	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150048

Period: From 01/01/2013

Worksheet K

Hospice CCN: 151524

To 12/31/2013

Date/Time Prepared: 5/27/2014 8:01 am

		Hospice I					
		Total (col. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	420	0	420	0	420	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	602,156	0	602,156	-54	602,102	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	236,061	0	236,061	0	236,061	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	615,778	0	615,778	0	615,778	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	86,396	0	86,396	0	86,396	18.00
19.00	Home Health Aide and Homemaker	22,718	0	22,718	0	22,718	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	236,528	0	236,528	0	236,528	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	4	0	4	0	4	24.00
25.00	Other - Specify	2,540	0	2,540	0	2,540	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	1,802,601	0	1,802,601	-54	1,802,547	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150048

Period: From 01/01/2013

Worksheet K-1

Hospice CCN: 151524

To 12/31/2013

Date/Time Prepared: 5/27/2014 8:01 am

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	87,378	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	597,832	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	87,378	0	0	0	597,832	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150048

Period: From 01/01/2013

Worksheet K-1

Hospice CCN: 151524

To 12/31/2013

Date/Time Prepared: 5/27/2014 8:01 am

		Hospice I				
		Total Therapists	Aides	All-Other	Total (1)	
		6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	41,639	129,017	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	217,056	217,056	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services		0	0	0	9.00
10.00	Nursing Care		0	17,946	615,778	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services		0	0	0	15.00
16.00	Spiritual Counseling		0	0	0	16.00
17.00	Dietary Counseling		0	0	0	17.00
18.00	Counseling - Other		0	86,396	86,396	18.00
19.00	Home Health Aide and Homemaker		22,718	0	22,718	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	0	0	27.00
28.00	Imaging Services		0	0	0	28.00
29.00	Labs and Diagnostics		0	0	0	29.00
30.00	Medical Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radiation Therapy		0	0	0	32.00
33.00	Chemotherapy		0	0	0	33.00
34.00	Other		0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0	35.00
36.00	Volunteer Program Costs		0	0	0	36.00
37.00	Fundraising		0	0	0	37.00
38.00	Other Program Costs		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	22,718	363,037	1,070,965	39.00

HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)

Provider CCN: 150048

Period: From 01/01/2013

Worksheet K-2

Hospice CCN: 151524

To 12/31/2013

Date/Time Prepared: 5/27/2014 8:01 am

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	0	0	39.00

HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)

Provider CCN: 150048

Period: From 01/01/2013

Worksheet K-2

Hospice CCN: 151524

To 12/31/2013

Date/Time Prepared: 5/27/2014 8:01 am

		Hospice I				
		Total Therapists	Aides	All-Other	Total (1)	
		6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	62,862	62,862	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	15,194	15,194	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services		0	0	0	9.00
10.00	Nursing Care		0	0	0	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services		0	0	0	15.00
16.00	Spiritual Counseling		0	0	0	16.00
17.00	Dietary Counseling		0	0	0	17.00
18.00	Counseling - Other		0	0	0	18.00
19.00	Home Health Aide and Homemaker		0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	0	0	27.00
28.00	Imaging Services		0	0	0	28.00
29.00	Labs and Diagnostics		0	0	0	29.00
30.00	Medical Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radiation Therapy		0	0	0	32.00
33.00	Chemotherapy		0	0	0	33.00
34.00	Other		0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0	35.00
36.00	Volunteer Program Costs		0	0	0	36.00
37.00	Fundraising		0	0	0	37.00
38.00	Other Program Costs		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	78,056	78,056	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 150048

Period: From 01/01/2013

Worksheet K-4

Hospice CCN: 151524

To 12/31/2013

Part I
Date/Time Prepared:
5/27/2014 8:01 am

		CAPITAL RELATED COST					
		NET EXPENSES FOR COST ALLOCATION	BUI LDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	420		420			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	602,102	0	420	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	236,061	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	615,778	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	86,396	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	22,718	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	236,528	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	4	0	0	0	0	24.00
25.00	Other - Specify	2,540	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	1,802,547	0	420	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 150048

Period: From 01/01/2013

Worksheet K-4

Hospice CCN: 151524

To 12/31/2013

Part I
Date/Time Prepared:
5/27/2014 8:01 am

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (col s. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col . 5A ± col . 6)	
		5.00	5A	6.00	7.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance					3.00
4.00	Transportation - Staff					4.00
5.00	Volunteer Service Coordination	0				5.00
6.00	Administrative and General	0	602,522	602,522		6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	236,061	118,524	354,585	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services	0	0	0	0	9.00
10.00	Nursing Care	0	615,778	309,176	924,954	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	17.00
18.00	Counseling - Other	0	86,396	43,379	129,775	18.00
19.00	Home Health Aide and Homemaker	0	22,718	11,407	34,125	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	20.00
21.00	Other	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	236,528	118,759	355,287	22.00
23.00	Analgesics	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	4	2	6	24.00
25.00	Other - Specify	0	2,540	1,275	3,815	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	33.00
34.00	Other	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	1,802,547		1,802,547	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150048

Period: From 01/01/2013

Worksheet K-4

Hospice CCN: 151524

To 12/31/2013

Part II
Date/Time Prepared:
5/27/2014 8:01 am

	CAPITAL RELATED COST					Hospice I
	BUILDINGS & FIXTURES (SQ. FT.)	MOVABLE EQUIPMENT (\$ VALUE)	PLANT OPERATION & MAINT. (SQ. FT.)	TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICES COORDINATOR (HOURS)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	445				1.00
2.00	Capital Related Costs-Movable Equip.	0	445			2.00
3.00	Plant Operation and Maintenance	0	0	445		3.00
4.00	Transportation - Staff	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	5.00
6.00	Administrative and General	445	445	445	0	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	20.00
21.00	Other	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	33.00
34.00	Other	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)	0	420	0	0	39.00
40.00	Unit Cost Multiplier	0.000000	0.943820	0.000000	0.000000	40.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150048

Period: From 01/01/2013

Worksheet K-4

Hospice CCN: 151524

To 12/31/2013

Part II
Date/Time Prepared:
5/27/2014 8:01 am

Hospice I

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	
		6A	6.00	
GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0		1.00
2.00	Capital Related Costs-Movable Equip.	0		2.00
3.00	Plant Operation and Maintenance	0		3.00
4.00	Transportation - Staff	0		4.00
5.00	Volunteer Service Coordination			5.00
6.00	Administrative and General	-602,522	1,200,025	6.00
INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	236,061	7.00
8.00	Inpatient - Respite Care	0	0	8.00
VISITING SERVICES				
9.00	Physician Services	0	0	9.00
10.00	Nursing Care	0	615,778	10.00
11.00	Nursing Care-Continuous Home Care	0	0	11.00
12.00	Physical Therapy	0	0	12.00
13.00	Occupational Therapy	0	0	13.00
14.00	Speech/ Language Pathology	0	0	14.00
15.00	Medical Social Services	0	0	15.00
16.00	Spiritual Counseling	0	0	16.00
17.00	Dietary Counseling	0	0	17.00
18.00	Counseling - Other	0	86,396	18.00
19.00	Home Health Aide and Homemaker	0	22,718	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	20.00
21.00	Other	0	0	21.00
OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	236,528	22.00
23.00	Analgesics	0	0	23.00
24.00	Sedatives / Hypnotics	0	4	24.00
25.00	Other - Specify	0	2,540	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	26.00
27.00	Patient Transportation	0	0	27.00
28.00	Imaging Services	0	0	28.00
29.00	Labs and Diagnostics	0	0	29.00
30.00	Medical Supplies	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	31.00
32.00	Radiation Therapy	0	0	32.00
33.00	Chemotherapy	0	0	33.00
34.00	Other	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0	35.00
36.00	Volunteer Program Costs	0	0	36.00
37.00	Fundraising	0	0	37.00
38.00	Other Program Costs	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		602,522	39.00
40.00	Unit Cost Multiplier		0.502091	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150048

Period: From 01/01/2013

Worksheet K-5

Hospice CCN: 151524

To 12/31/2013

Part I
Date/Time Prepared:
5/27/2014 8:01 am

Hospice I

Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE	NEW MVBLE EQUIP		
		0	1.00	1.01		
1.00 Administrative and General		8,850	0	0	18,719	1.00
2.00 Inpatient - General Care	354,585	0	0	0	31,493	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	4.00
5.00 Nursing Care	924,954	0	0	0	89,345	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	129,775	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	34,125	0	0	0	12,535	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	3,296	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	355,287	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	6	0	0	0	0	19.00
20.00 Other - Specify	3,815	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	1,802,547	8,850	0	0	155,388	34.00
35.00 Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150048

Period: From 01/01/2013

Worksheet K-5

Hospice CCN: 151524

To 12/31/2013

Part I
Date/Time Prepared:
5/27/2014 8:01 am

Cost Center Description		Hospice I					
		NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	
		5.01	5.02	5.03	5.04	5.05	
1.00	Administrative and General	1,662	22,032	43,575	12,316	19,066	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	1,662	22,032	43,575	12,316	19,066	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150048

Period: From 01/01/2013

Worksheet K-5

Hospice CCN: 151524

To 12/31/2013

Part I
Date/Time Prepared:
5/27/2014 8:01 am

Cost Center Description		Subtotal	Hospice I				
			OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5A.05	5.06	7.00	8.00	9.00	
1.00	Administrative and General	126,220	7,198	0	0	16,253	1.00
2.00	Inpatient - General Care	386,078	22,018	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	1,014,299	57,848	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	129,775	7,401	0	0	0	13.00
14.00	Home Health Aide and Homemaker	46,660	2,661	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	3,296	188	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	355,287	20,262	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	6	0	0	0	0	19.00
20.00	Other - Specify	3,815	218	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	2,065,436	117,794	0	0	16,253	34.00
35.00	Unit Cost Multiplier (see instructions)	0.000000					35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150048

Period:

Worksheet K-5

Hospice CCN: 151524

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

Part I
Date/Time Prepared:
5/27/2014 8:01 am

Cost Center Description		Hospice I					
		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	0	11,435	0	0	265,158	1.00
2.00	Inpatient - General Care	0	0	0	537	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	11,435	0	537	265,158	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150048

Period: From 01/01/2013

Worksheet K-5

Hospice CCN: 151524

To 12/31/2013

Part I
Date/Time Prepared:
5/27/2014 8:01 am

Cost Center Description		Hospice I				Subtotal (col s. 4A-23)	
		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INSERVICE EDUCATION	PARAMED PRGM		
		16.00	17.00	17.01	23.00	24.00	
1.00	Administrative and General	22,873	0	22,795	0	471,932	1.00
2.00	Inpatient - General Care	0	0	0	0	408,633	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	1,072,147	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	137,176	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	49,321	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	3,484	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	375,549	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	6	19.00
20.00	Other - Specify	0	0	0	0	4,033	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	22,873	0	22,795	0	2,522,281	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS		Provider CCN: 150048	Period: From 01/01/2013	Worksheet K-5 Part I Date/Time Prepared: 5/27/2014 8:01 am
		Hospice CCN: 151524	To 12/31/2013	

Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (col.s. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (col.s. 26 ± 27)		
	25.00	26.00	27.00	28.00		
1.00 Administrative and General						1.00
2.00 Inpatient - General Care	0	408,633	94,056	502,689		2.00
3.00 Inpatient - Respite Care	0	0	0	0		3.00
4.00 Physician Services	0	0	0	0		4.00
5.00 Nursing Care	0	1,072,147	246,778	1,318,925		5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0		6.00
7.00 Physical Therapy	0	0	0	0		7.00
8.00 Occupational Therapy	0	0	0	0		8.00
9.00 Speech/ Language Pathology	0	0	0	0		9.00
10.00 Medical Social Services	0	0	0	0		10.00
11.00 Spiritual Counseling	0	0	0	0		11.00
12.00 Dietary Counseling	0	0	0	0		12.00
13.00 Counseling - Other	0	137,176	31,574	168,750		13.00
14.00 Home Health Aide and Homemaker	0	49,321	11,352	60,673		14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	3,484	802	4,286		15.00
16.00 Other	0	0	0	0		16.00
17.00 Drugs, Biological and Infusion Therapy	0	375,549	86,441	461,990		17.00
18.00 Analgesics	0	0	0	0		18.00
19.00 Sedatives / Hypnotics	0	6	1	7		19.00
20.00 Other - Specify	0	4,033	928	4,961		20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0		21.00
22.00 Patient Transportation	0	0	0	0		22.00
23.00 Imaging Services	0	0	0	0		23.00
24.00 Labs and Diagnostics	0	0	0	0		24.00
25.00 Medical Supplies	0	0	0	0		25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0		26.00
27.00 Radiation Therapy	0	0	0	0		27.00
28.00 Chemotherapy	0	0	0	0		28.00
29.00 Other	0	0	0	0		29.00
30.00 Bereavement Program Costs	0	0	0	0		30.00
31.00 Volunteer Program Costs	0	0	0	0		31.00
32.00 Fundraising	0	0	0	0		32.00
33.00 Other Program Costs	0	0	0	0		33.00
34.00 Total (sum of lines 1 thru 33) (2)	0	2,522,281		2,522,281		34.00
35.00 Unit Cost Multiplier (see instructions)			0.230172			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150048

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

Worksheet K-5
Part II
Date/Time Prepared:
5/27/2014 8:01 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (PHONES)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW CAP BLDG & FIXT - OFFSITE (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)			
	1.00	1.01	2.00			
1.00 Administrative and General	445	0	0	129,017	13	1.00
2.00 Inpatient - General Care	0	0	0	217,056	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	4.00
5.00 Nursing Care	0	0	0	615,778	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	86,396	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	22,718	0	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	445	0	0	1,070,965	13	34.00
35.00 Total cost to be allocated	8,850	0	0	155,388	1,662	35.00
36.00 Unit Cost Multiplier (see instructions)	19.887640	0.000000	0.000000	0.145092	127.846154	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150048
Hospice CCN: 151524

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

Worksheet K-5
Part II
Date/Time Prepared:
5/27/2014 8:01 am

Cost Center Description		Hospice I				Reconciliation	
		DATA PROCESSING (TERMINALS)	PURCHASING RECEIVING AND STORES (SUPPLY EXPENSE)	ADMITTING (TOTAL REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (TOTAL REVENUE)		
		5.02	5.03	5.04	5.05	5A.06	
1.00	Administrative and General	3	2,514	3,188,270	3,188,270	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	3	2,514	3,188,270	3,188,270		34.00
35.00	Total cost to be allocated	22,032	43,575	12,316	19,066		35.00
36.00	Unit Cost Multiplier (see instructions)	7,344.000000	17.332936	0.003863	0.005980		36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150048

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

Worksheet K-5
Part II
Date/Time Prepared:
5/27/2014 8:01 am

Cost Center Description	Hospice I					
	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
	5.06	7.00	8.00	9.00	10.00	
1.00 Administrative and General	126,220	0	0	95	0	1.00
2.00 Inpatient - General Care	386,078	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	4.00
5.00 Nursing Care	1,014,299	0	0	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	129,775	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	46,660	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	3,296	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	355,287	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	6	0	0	0	0	19.00
20.00 Other - Specify	3,815	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	2,065,436	0	0	95	0	34.00
35.00 Total cost to be allocated	117,794	0	0	16,253	0	35.00
36.00 Unit Cost Multiplier (see instructions)	0.057031	0.000000	0.000000	171.084211	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150048
Hospice CCN: 151524

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

Worksheet K-5
Part II
Date/Time Prepared:
5/27/2014 8:01 am

Cost Center Description		Hospice I					
		CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (MED SUPPLIES)	PHARMACY (DRUGS)	MEDICAL RECORDS & LIBRARY (TOTAL REVENUE)	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	36,722	0	0	236,528	3,188,270	1.00
2.00	Inpatient - General Care	0	0	2,540	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	36,722	0	2,540	236,528	3,188,270	34.00
35.00	Total cost to be allocated	11,435	0	537	265,158	22,873	35.00
36.00	Unit Cost Multiplier (see instructions)	0.311394	0.000000	0.211417	1.121043	0.007174	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150048

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

Worksheet K-5
Part II
Date/Time Prepared:
5/27/2014 8:01 am

Cost Center Description		Hospice I			
		SOCIAL SERVICE (TIME SPENT)	INSERVICE EDUCATION (IN HOUSE ED)	PARAMED ED PRGM (TIME SPENT)	
		17.00	17.01	23.00	
1.00	Administrative and General	0	429	0	1.00
2.00	Inpatient - General Care	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	3.00
4.00	Physician Services	0	0	0	4.00
5.00	Nursing Care	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	6.00
7.00	Physical Therapy	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	9.00
10.00	Medical Social Services	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	12.00
13.00	Counseling - Other	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	15.00
16.00	Other	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	17.00
18.00	Analgesics	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	19.00
20.00	Other - Specify	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	21.00
22.00	Patient Transportation	0	0	0	22.00
23.00	Imaging Services	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	24.00
25.00	Medical Supplies	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	27.00
28.00	Chemotherapy	0	0	0	28.00
29.00	Other	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	31.00
32.00	Fundraising	0	0	0	32.00
33.00	Other Program Costs	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	429	0	34.00
35.00	Total cost to be allocated	0	22,795	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	53.135198	0.000000	36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS		Provider CCN: 150048	Period: From 01/01/2013	Worksheet K-5		
		Hospice CCN: 151524	To 12/31/2013	Part III Date/Time Prepared: 5/27/2014 8:01 am		
Cost Center Description		Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1.00	2.00	3.00	
ANCI LLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.708844	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00				2.00
3.00	SPEECH PATHOLOGY	68.00				3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.307871	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0.456779	0	0	5.00
6.00	LABORATORY	60.00	0.171800	0	0	6.00
6.01	BLOOD LABORATORY	60.01				6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.078771	0	0	7.00
8.00	PATIENT CARE CENTER - OCC	93.00	0.609497	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00				9.00
10.00	OTHER ANCI LLARY SERVICE COST CENTERS	76.00	0.000000	0	0	10.00
10.01	NEURODIAGNOSTIC	76.01	0.018256	0	0	10.01
10.97	CARDIAC REHABILITATION	76.97	0.444479	0	0	10.97
11.00	Totals (sum of lines 1-10)					11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 150048

Period: From 01/01/2013

Worksheet K-6

Hospice CCN: 151524

To 12/31/2013

Date/Time Prepared: 5/27/2014 8:01 am

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				2,522,281	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				15,446	2.00
3.00	Average cost per diem (line 1 divided by line 2)				163.30	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	9,986				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	1,630,714				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		1,835			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		299,656			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	7,275				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	1,188,008				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		44			10.00
11.00	Aggregate NF cost (line 3 times line 10)		7,185			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			3,625		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			591,963		13.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150048	Period: From 01/01/2013 To 12/31/2013	Worksheet L Parts I-III Date/Time Prepared: 5/27/2014 8:01 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		3,375,120	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		371,386	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		101.31	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		0	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		3,746,506	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00