

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: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet S Parts I-III Date/Time Prepared: 5/27/2014 7:26 pm
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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: 7:26 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION
 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 ADVENTIST GLENOAKS HOSPITAL (140292) 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	180,664	11,137	27,892	0	1.00
2.00 Subprovider - IPF	0	24,659	2		0	2.00
3.00 Subprovider - IRF	0	0	0		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	205,323	11,139	27,892	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: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/27/2014 7:21 pm
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1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 Zip Code: 60139-		4.00 County: DUPAGE				1.00	
1.00	Street: 701 WINTHROP AVENUE	2.00 State: IL		3.00 Zip Code: 60139-		4.00 County: DUPAGE				2.00	
2.00	City: GLENDALE HEIGHTS										

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
						V	XVIII	XIX		
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	ADVENTIST GLENOAKS HOSPITAL	140292	16974	1	11/23/1982	N	P	O	3.00
4.00	Subprovider - IPF	GLEN OAKS MED CTR PSYCH UNIT	14S292	16974	4	01/01/1984	N	P	T	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

						From:	To:					
						1.00	2.00					
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2013	12/31/2013				20.00	
21.00	Type of Control (see instructions)					1						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				22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	Y				22.01
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N				23.00

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
								1.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.							24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.							25.00
	5,418	1,127	0	35	2,393	0		
	0	0	0	0	0			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/27/2014 7:21 pm		
		Urban/Rural S	Date of Geogr			
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0			35.00	
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N		39.00	
		V	XVII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	Y	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)	N			60.00	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		
61.04	Enter the number of unweighted primary care/surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 140292

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

Worksheet S-2
Part I
Date/Time Prepared:
5/27/2014 7:21 pm

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))
				1.00	2.00	3.00
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000 64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/27/2014 7:21 pm																																																																																																																						
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(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)</td> <td></td> <td></td> <td>N</td> </tr> <tr> <td colspan="6">Inpatient Rehabilitation Facility PPS</td> </tr> <tr> <td>75.00</td> <td>Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.</td> <td></td> <td></td> <td>N</td> </tr> <tr> <td>76.00</td> <td>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. 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(see instructions) Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td></td> <td>N</td> </tr> <tr> <td>93.00</td> <td>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.</td> <td></td> <td>N</td> <td>N</td> </tr> <tr> <td>94.00</td> <td>Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>N</td> </tr> <tr> <td>95.00</td> <td>If line 94 is "Y", enter the reduction percentage in the applicable column.</td> <td></td> <td>0.00</td> <td>0.00</td> </tr> </tbody> </table> </td> </tr> </tbody> </table> </td></tr></tbody></table>								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.			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		V	XIX			
		1.00	2.00			
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	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)			106.00		
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)			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	
		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
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			N		
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.			Y		
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			2		
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	524,832	0	0		
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N		
119.00	DO NOT USE THIS LINE					
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.			N	N	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.			Y		
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		
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					
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132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					

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		1.00	2.00		
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HF8013	140.00	
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: ADVENTIST HEALTH SYSTEM	Contractor's Name: FIRST COAST SERVICE OPTIONS		Contractor's Number: 09001	
142.00	Street: 900 HOPE WAY	PO Box:		142.00	
143.00	City: ALTAMONTE SPRINGS	State: FL	Zip Code: 32714	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
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
				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
		0	1.00	2.00	3.00
					4.00
					5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5				0.00
				1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act					
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			0	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.50	
		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)	10/01/2012		09/30/2013	
				170.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/27/2014 7:21 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
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	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/02/2014	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	1.00 N	2.00	3.00 N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				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.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				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.				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				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				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.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?	Y			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y			37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N			40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MI KE	THOMPSON		41.00
42.00	Enter the employer/company name of the cost report preparer.	ADVENTIST HEALTH SYSTEM SUNBELT			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	407-357-2338	MI KE. THOMPSON3@AHSS.ORG		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)	04/02/2014		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		REIMBURSEMENT MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

VOLUNTARY CONTACT INFORMATION

Provider CCN: 140292

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

Worksheet S-2
Part V
Date/Time Prepared:
5/27/2014 7:21 pm

		1.00	
Cost Report Preparer Contact Information			
1.00	First Name	MI KE	1.00
2.00	Last Name	THOMPSON	2.00
3.00	Title	REIMBURSEMENT MANAGER	3.00
4.00	Employer	ADVENTIST HEALTH SYSTEM SUNBELT	4.00
5.00	Phone Number	(407)357-2338	5.00
6.00	E-mail Address	MI KE.THOMPSON3@AHSS.ORG	6.00
7.00	Department	CORPORATE REIMBURSEMENT	7.00
8.00	Mailing Address 1	900 HOPE WAY	8.00
9.00	Mailing Address 2		9.00
10.00	City	ALTAMONTE SPRINGS	10.00
11.00	State	FL	11.00
12.00	Zip	32714	12.00
Officer or Administrator of Provider Contact Information			
13.00	First Name	ERIC	13.00
14.00	Last Name	MOOTS	14.00
15.00	Title	VP/CFO	15.00
16.00	Employer	ADVENTIST GLENOAKS HOSPITAL	16.00
17.00	Phone Number	(630)545-3901	17.00
18.00	E-mail Address	ERIC.MOOTS@AHSS.ORG	18.00
19.00	Department		19.00
20.00	Mailing Address 1	701 WINTHROP AVENUE	20.00
21.00	Mailing Address 2		21.00
22.00	City	GLENDAL HEIGHTS	22.00
23.00	State	IL	23.00
24.00	Zip	60139	24.00

HFS Supplemental Information		Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part IX Date/Time Prepared: 5/27/2014 7:21 pm
		Title V 1.00	Title XIX 2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient 1.00	Outpatient 2.00	
CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V 1.00	Title XIX 2.00	
RCE DISALLOWANCE				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140292

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

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2014 7:21 pm

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	114	41,610	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)		114	41,610	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	10	3,650	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)		124	45,260	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	16	5,840		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		140				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: 140292

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

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2014 7:21 pm

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)	8,881	4,459	21,666			1.00
2.00 HMO and other (see instructions)	217	3,484				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	8,881	4,459	21,666			7.00
8.00 INTENSIVE CARE UNIT	1,399	260	2,476			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		699	862			13.00
14.00 Total (see instructions)	10,280	5,418	25,004	0.00	499.60	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	4,242	247	5,143	0.00	30.99	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	72			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	530.59	27.00
28.00 Observation Bed Days		191	1,459			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	71	84			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: 140292

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

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2014 7:21 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,665	1,544	4,928	1.00
2.00 HMO and other (see instructions)			50			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	1,665	1,544	4,928	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	267	17	354	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140292

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

Worksheet S-3
Part II
Date/Time Prepared:
5/27/2014 7:21 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation 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	37,018,572	217,228	37,235,800	1,169,230.00	31.85
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		251,213	0	251,213	3,619.00	69.42
6.00	Non-physician-Part B		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		769,711	0	769,711	12,021.00	64.03
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		6,040,800	-168,879	5,871,921	190,029.00	30.90
OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		812,619	0	812,619	18,393.00	44.18
12.00	Contract management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		561,652	0	561,652	3,756.00	149.53
14.00	Home office salaries & wage-related costs		396,655	0	396,655	6,195.00	64.03
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		5,908,742	0	5,908,742		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		1,143,054	0	1,143,054		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		31,178	0	31,178		
24.00	Wage-related costs (RHC/FOHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	307,008	56,952	363,960	11,540.00	31.54
27.00	Administrative & General	5.00	4,928,877	-449,051	4,479,826	127,079.00	35.25
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	899,234	67,493	966,727	41,278.00	23.42
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00
32.00	Housekeeping	9.00	751,435	200	751,635	53,192.00	14.13
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	910,671	-639,271	271,400	16,259.00	16.69
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	639,271	639,271	38,298.00	16.69
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	840,988	235,270	1,076,258	25,119.00	42.85
39.00	Central Services and Supply	14.00	303,646	63,430	367,076	18,173.00	20.20
40.00	Pharmacy	15.00	1,431,665	-121,292	1,310,373	32,917.00	39.81
41.00	Medical Records & Medical Records Library	16.00	429,240	159,182	588,422	27,030.00	21.77

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140292

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

Worksheet S-3
Part II
Date/Time Prepared:
5/27/2014 7:21 pm

		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	689,033	0	689,033	18,059.00	38.15	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: 140292

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

Worksheet S-3
Part III
Date/Time Prepared:
5/27/2014 7:21 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation 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 III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	35,997,648	217,228	36,214,876	1,153,590.00	31.39	1.00
2.00	Excluded area salaries (see instructions)	6,040,800	-168,879	5,871,921	190,029.00	30.90	2.00
3.00	Subtotal salaries (line 1 minus line 2)	29,956,848	386,107	30,342,955	963,561.00	31.49	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,770,926	0	1,770,926	28,344.00	62.48	4.00
5.00	Subtotal wage-related costs (see inst.)	5,908,742	0	5,908,742	0.00	19.47	5.00
6.00	Total (sum of lines 3 thru 5)	37,636,516	386,107	38,022,623	991,905.00	38.33	6.00
7.00	Total overhead cost (see instructions)	11,491,797	12,184	11,503,981	408,944.00	28.13	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet S-3 Part IV Date/Time Prepared: 5/27/2014 7:21 pm
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	808,860	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)	3,028,284	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	23,916	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	472,449	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	2,474,358	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	96,715	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	178,392	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	7,082,974	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: 140292

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

Worksheet S-3
Part V
Date/Time Prepared:
5/27/2014 7:21 pm

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	812,619	7,082,974	1.00
2.00	Hospital	698,017	5,939,920	2.00
3.00	Subprovider - IPF	114,602	381,365	3.00
4.00	Subprovider - IRF			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			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	761,689	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet S-10 Date/Time Prepared: 5/27/2014 7:21 pm
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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)		0.272309		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		6,917,011		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		14,799,017		5.00
6.00	Medicaid charges		63,507,964		6.00
7.00	Medicaid cost (line 1 times line 6)		17,293,790		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0		8.00
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)		3,007,707		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		819,026		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)		819,026		16.00
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		819,026		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	12,436,221	0	12,436,221	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	3,386,495	0	3,386,495	21.00
22.00	Partial payment by patients approved for charity care	5,628	0	5,628	22.00
23.00	Cost of charity care (line 21 minus line 22)	3,380,867	0	3,380,867	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		3,917,585		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		553,414		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		3,364,171		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		916,094		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		4,296,961		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		5,115,987		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140292

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

Worksheet A
Date/Time Prepared:
5/27/2014 7:21 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		0	0	1,808,129	1,808,129	1.00
2.00	00200		0	0	2,556,233	2,556,233	2.00
4.00	00400				297,838	5,220,481	4.00
5.01	00510	307,008	4,615,635	4,922,643	297,838	5,220,481	4.00
5.01	00510	0	305,177	305,177	3,357	308,534	5.01
5.04	00513	739,082	504,885	1,243,967	-1,780	1,242,187	5.04
5.06	00560	4,189,795	17,346,884	21,536,679	-1,760,086	19,776,593	5.06
7.00	00700	899,234	1,669,242	2,568,476	252,071	2,820,547	7.00
9.00	00900	751,435	506,343	1,257,778	-1,200	1,256,578	9.00
10.00	01000	910,671	676,683	1,587,354	-1,115,898	471,456	10.00
11.00	01100	0	0	0	1,114,288	1,114,288	11.00
13.00	01300	840,988	135,317	976,305	311,377	1,287,682	13.00
14.00	01400	303,646	-24,239	279,407	95,096	374,503	14.00
15.00	01500	1,431,665	2,417,111	3,848,776	-2,429,176	1,419,600	15.00
16.00	01600	429,240	107,325	536,565	257,537	794,102	16.00
17.00	01700	689,033	388,805	1,077,838	-120	1,077,718	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	9,082,448	2,139,825	11,222,273	-1,202,123	10,020,150	30.00
31.00	03100	1,901,913	368,856	2,270,769	-120	2,270,649	31.00
40.00	04000	2,104,025	303,820	2,407,845	-283,909	2,123,936	40.00
43.00	04300	0	3,927	3,927	530,147	534,074	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,304,550	425,768	1,730,318	-25,350	1,704,968	50.00
51.00	05100	283,134	26,565	309,699	0	309,699	51.00
52.00	05200	0	790	790	954,805	955,595	52.00
53.00	05300	45,566	46,931	92,497	-230	92,267	53.00
54.00	05400	823,880	279,738	1,103,618	-44,734	1,058,884	54.00
56.00	05600	154,345	116,112	270,457	-92,484	177,973	56.00
57.00	05700	394,238	43,853	438,091	0	438,091	57.00
58.00	05800	152,588	18,220	170,808	-120	170,688	58.00
59.00	05900	507,244	717,494	1,224,738	-321,182	903,556	59.00
60.00	06000	1,263,769	1,063,020	2,326,789	19,180	2,345,969	60.00
65.00	06500	655,088	182,219	837,307	-240	837,067	65.00
66.00	06600	226,555	359,400	585,955	-72,162	513,793	66.00
67.00	06700	53,493	31,973	85,466	0	85,466	67.00
68.00	06800	19,056	5,059	24,115	0	24,115	68.00
69.00	06900	352,387	133,162	485,549	-648	484,901	69.00
70.00	07000	15,064	17,541	32,605	0	32,605	70.00
71.00	07100	0	1,386,621	1,386,621	568,388	1,955,009	71.00
72.00	07200	0	2,233,565	2,233,565	-473,015	1,760,550	72.00
73.00	07300	0	0	0	1,883,328	1,883,328	73.00
74.00	07400	0	147,970	147,970	0	147,970	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	197,842	58,993	256,835	-28,293	228,542	90.00
91.00	09100	2,052,815	1,179,459	3,232,274	-400	3,231,874	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		1,967,921	1,967,921	-3,152,074	-1,184,153	113.00
118.00		33,081,797	41,907,970	74,989,767	-353,570	74,636,197	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	39,185	14,479	53,664	0	53,664	190.00
192.00	19200	164,979	6,600,986	6,765,965	0	6,765,965	192.00
192.03	19203	0	0	0	353,570	353,570	192.03
194.00	07950	106,531	19,604	126,135	0	126,135	194.00
194.01	07951	115,773	192,351	308,124	0	308,124	194.01
194.03	07953	3,510,307	1,282,357	4,792,664	0	4,792,664	194.03
200.00		37,018,572	50,017,747	87,036,319	0	87,036,319	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140292

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

Worksheet A
Date/Time Prepared:
5/27/2014 7:21 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	765,548	2,573,677	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	120,330	2,676,563	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	479,662	5,700,143	4.00
5.01	00510	COMMUNICATIONS	-81,211	227,323	5.01
5.04	00513	ADMINISTRATIVE	0	1,242,187	5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	-8,132,224	11,644,369	5.06
7.00	00700	OPERATION OF PLANT	234,945	3,055,492	7.00
9.00	00900	HOUSEKEEPING	0	1,256,578	9.00
10.00	01000	DIETARY	-112,528	358,928	10.00
11.00	01100	CAFETERIA	0	1,114,288	11.00
13.00	01300	NURSING ADMINISTRATION	77,927	1,365,609	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	117,853	492,356	14.00
15.00	01500	PHARMACY	12,764	1,432,364	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	249,228	1,043,330	16.00
17.00	01700	SOCIAL SERVICE	0	1,077,718	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-546,000	9,474,150	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,270,649	31.00
40.00	04000	SUBPROVIDER - IPF	-50	2,123,886	40.00
43.00	04300	NURSERY	0	534,074	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,704,968	50.00
51.00	05100	RECOVERY ROOM	0	309,699	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	955,595	52.00
53.00	05300	ANESTHESIOLOGY	0	92,267	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,444	1,056,440	54.00
56.00	05600	RADIOISOTOPE	0	177,973	56.00
57.00	05700	CT SCAN	0	438,091	57.00
58.00	05800	MRI	0	170,688	58.00
59.00	05900	CARDIAC CATHETERIZATION	-98,048	805,508	59.00
60.00	06000	LABORATORY	123,373	2,469,342	60.00
65.00	06500	RESPIRATORY THERAPY	0	837,067	65.00
66.00	06600	PHYSICAL THERAPY	-43	513,750	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	85,466	67.00
68.00	06800	SPEECH PATHOLOGY	0	24,115	68.00
69.00	06900	ELECTROCARDIOLOGY	-73,661	411,240	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	32,605	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-351,776	1,603,233	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,760,550	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-681	1,882,647	73.00
74.00	07400	RENAL DIALYSIS	0	147,970	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-48,426	180,116	90.00
91.00	09100	EMERGENCY	-815,448	2,416,426	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	1,184,153	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-6,896,757	67,739,440	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	53,664	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,765,965	192.00
192.03	19203	OP PHARMACY	0	353,570	192.03
194.00	07950	FOUNDATION	0	126,135	194.00
194.01	07951	MARKETING	0	308,124	194.01
194.03	07953	THERAPEUTIC DAY SCHOOL	0	4,792,664	194.03
200.00		TOTAL (SUM OF LINES 118-199)	-6,896,757	80,139,562	200.00

COST CENTERS USED IN COST REPORT		Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet Non-CMS W Date/Time Prepared: 5/27/2014 7:21 pm
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Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
	1.00	2.00	
GENERAL SERVICE COST CENTERS			
1.00 CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00 EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.01 COMMUNICATIONS	00510		5.01
5.04 ADMINISTRATION	00513		5.04
5.06 OTHER ADMINISTRATIVE AND GENERAL	00560		5.06
7.00 OPERATION OF PLANT	00700		7.00
9.00 HOUSEKEEPING	00900		9.00
10.00 DIETARY	01000		10.00
11.00 CAFETERIA	01100		11.00
13.00 NURSING ADMINISTRATION	01300		13.00
14.00 CENTRAL SERVICES & SUPPLY	01400		14.00
15.00 PHARMACY	01500		15.00
16.00 MEDICAL RECORDS & LIBRARY	01600		16.00
17.00 SOCIAL SERVICE	01700		17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS	03000		30.00
31.00 INTENSIVE CARE UNIT	03100		31.00
40.00 SUBPROVIDER - IPF	04000		40.00
43.00 NURSERY	04300		43.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	05000		50.00
51.00 RECOVERY ROOM	05100		51.00
52.00 DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00 ANESTHESIOLOGY	05300		53.00
54.00 RADIOLOGY-DIAGNOSTIC	05400		54.00
56.00 RADIOISOTOPE	05600		56.00
57.00 CT SCAN	05700		57.00
58.00 MRI	05800		58.00
59.00 CARDIAC CATHETERIZATION	05900		59.00
60.00 LABORATORY	06000		60.00
65.00 RESPIRATORY THERAPY	06500		65.00
66.00 PHYSICAL THERAPY	06600		66.00
67.00 OCCUPATIONAL THERAPY	06700		67.00
68.00 SPEECH PATHOLOGY	06800		68.00
69.00 ELECTROCARDIOLOGY	06900		69.00
70.00 ELECTROENCEPHALOGRAPHY	07000		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00 DRUGS CHARGED TO PATIENTS	07300		73.00
74.00 RENAL DIALYSIS	07400		74.00
OUTPATIENT SERVICE COST CENTERS			
90.00 CLINIC	09000		90.00
91.00 EMERGENCY	09100		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
SPECIAL PURPOSE COST CENTERS			
113.00 INTEREST EXPENSE	11300		113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS			
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00 PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.03 OP PHARMACY	19203		192.03
194.00 FOUNDATION	07950		194.00
194.01 MARKETING	07951		194.01
194.03 THERAPEUTIC DAY SCHOOL	07953		194.03
200.00 TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS

Provider CCN: 140292

Period:
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		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	639,271	475,017	1.00
	TOTALS		639,271	475,017	
B - NURSERY					
1.00	NURSERY	43.00	390,643	139,504	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	698,959	255,846	2.00
	TOTALS		1,089,602	395,350	
C - BILLABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,883,328	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	1,883,328	
D - BILLABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	568,388	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	TOTALS		0	568,388	
E - RENT AND LEASES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	253,058	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	886,978	2.00
3.00	COMMUNICATIONS	5.01	0	3,357	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
	TOTALS		0	1,143,393	
F - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,092,843	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,417,852	2.00
	TOTALS		0	2,510,695	
G - PSYCH					
1.00	ADULTS & PEDIATRICS	30.00	301,648	0	1.00
2.00	SUBPROVIDER - IPF	40.00	0	18,459	2.00
	TOTALS		301,648	18,459	
H - CNO					
1.00	NURSING ADMINISTRATION	13.00	163,703	70,556	1.00
	TOTALS		163,703	70,556	
I - RECRUITMENT BONUS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	2,905	0	1.00
2.00	HOUSEKEEPING	9.00	200	0	2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	48	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	438	0	4.00
5.00	OPERATING ROOM	50.00	115	0	5.00
	TOTALS		3,706	0	
J - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	45,791	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,000	2.00
	TOTALS		0	48,791	
K - OP PHARMACY					
1.00	OP PHARMACY	192.03	132,769	220,801	1.00
	TOTALS		132,769	220,801	

RECLASSIFICATIONS

Provider CCN: 140292

Period:
From 01/01/2013
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Worksheet A-6

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		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
L - PROPERTY TAX					
1.00	INTEREST EXPENSE	113.00	0	1,553,064	1.00
	TOTALS		0	1,553,064	
M - SHARED SERVICES					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	54,047	243,911	1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	1,696,097	1,558,404	2.00
3.00	OPERATION OF PLANT	7.00	67,493	185,318	3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	63,430	54,423	4.00
5.00	NURSING ADMINISTRATION	13.00	71,567	6,361	5.00
6.00	PHARMACY	15.00	11,477	1,288	6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	159,134	98,523	7.00
8.00	LABORATORY	60.00	71,722	51,651	8.00
9.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	213,522	0	9.00
	TOTALS		2,408,489	2,199,879	
N - INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,969,501	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	248,403	2.00
	TOTALS		0	2,217,904	
500.00	Grand Total: Increases		4,739,188	13,305,625	500.00

RECLASSIFICATIONS

Provider CCN: 140292

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

Worksheet A-6
Date/Time Prepared:
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		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - CAFETERIA						
1.00	DIETARY	10.00	639,271	475,017	0	1.00
	TOTALS		639,271	475,017		
B - NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	1,089,602	395,350	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		1,089,602	395,350		
C - BILLABLE DRUGS						
1.00	PHYSICAL THERAPY	66.00	0	86	0	1.00
2.00	PHARMACY	15.00	0	1,883,242	0	2.00
	TOTALS		0	1,883,328		
D - BILLABLE SUPPLIES						
1.00	PHARMACY	15.00	0	55	0	1.00
2.00	OPERATING ROOM	50.00	0	1,873	0	2.00
3.00	RADIOISOTOPE	56.00	0	92,484	0	3.00
4.00	LABORATORY	60.00	0	10	0	4.00
5.00	PHYSICAL THERAPY	66.00	0	951	0	5.00
6.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	473,015	0	6.00
	TOTALS		0	568,388		
E - RENT AND LEASES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	120	10	1.00
2.00	ADMINISTRATIVE AND GENERAL	5.04	0	1,780	10	2.00
3.00	OPERATION OF PLANT	5.06	0	313,230	0	3.00
4.00	HOUSEKEEPING	7.00	0	740	0	4.00
5.00	DIETARY	9.00	0	1,200	0	5.00
6.00	NURSING ADMINISTRATION	10.00	0	1,610	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	13.00	0	810	0	7.00
8.00	PHARMACY	14.00	0	22,757	0	8.00
9.00	MEDICAL RECORDS & LIBRARY	15.00	0	205,074	0	9.00
10.00	SOCIAL SERVICE	16.00	0	120	0	10.00
11.00	ADULTS & PEDIATRICS	17.00	0	120	0	11.00
12.00	INTENSIVE CARE UNIT	30.00	0	360	0	12.00
13.00	SUBPROVIDER - IPF	31.00	0	120	0	13.00
14.00	OPERATING ROOM	40.00	0	720	0	14.00
15.00	ANESTHESIOLOGY	50.00	0	23,477	0	15.00
16.00	RADIOLOGY-DIAGNOSTIC	53.00	0	230	0	16.00
17.00	MRI	54.00	0	44,734	0	17.00
18.00	CARDIAC CATHETERIZATION	58.00	0	120	0	18.00
19.00	LABORATORY	59.00	0	321,182	0	19.00
20.00	RESPIRATORY THERAPY	60.00	0	104,183	0	20.00
21.00	PHYSICAL THERAPY	65.00	0	240	0	21.00
22.00	ELECTROCARDIOLOGY	66.00	0	71,125	0	22.00
23.00	CLINIC	69.00	0	648	0	23.00
24.00	EMERGENCY	90.00	0	28,293	0	24.00
25.00		91.00	0	400	0	25.00
	TOTALS		0	1,143,393		
F - DEPRECIATION						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	23,461	9	1.00
2.00	INTEREST EXPENSE	113.00	0	2,487,234	9	2.00
	TOTALS		0	2,510,695		
G - PSYCH						
1.00	ADULTS & PEDIATRICS	30.00	0	18,459	0	1.00
2.00	SUBPROVIDER - IPF	40.00	301,648	0	0	2.00
	TOTALS		301,648	18,459		
H - CNO						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	163,703	70,556	0	1.00
	TOTALS		163,703	70,556		
I - RECRUITMENT BONUS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,905	0	1.00
2.00	HOUSEKEEPING	9.00	0	200	0	2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	48	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	438	0	4.00
5.00	OPERATING ROOM	50.00	0	115	0	5.00
	TOTALS		0	3,706		
J - INSURANCE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	48,791	12	1.00
2.00		0.00	0	0	12	2.00
	TOTALS		0	48,791		

RECLASSIFICATIONS

Provider CCN: 140292

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

Worksheet A-6

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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	K - OP PHARMACY						
1.00	PHARMACY	15.00	132,769	220,801	0		1.00
	TOTALS		132,769	220,801			
	L - PROPERTY TAX						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,553,064	13		1.00
	TOTALS		0	1,553,064			
	M - SHARED SERVICES						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	2,194,967	2,199,879	0		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	213,522	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
	TOTALS		2,194,967	2,413,401			
	N - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	2,217,904	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	2,217,904			
500.00	Grand Total: Decreases		4,521,960	13,522,853			500.00

RECLASSIFICATIONS

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

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Increases			Decreases			
Cost Center	Line #	Salary	Cost Center	Line #	Salary	
2.00	3.00	4.00	6.00	7.00	8.00	
A - CAFETERIA						
1.00	CAFETERIA	11.00	639,271	DIETARY	10.00	639,271
	TOTALS		639,271	TOTALS		639,271
B - NURSERY						
1.00	NURSERY	43.00	390,643	ADULTS & PEDIATRICS	30.00	1,089,602
2.00	DELIVERY ROOM & LABOR ROOM	52.00	698,959		0.00	0
	TOTALS		1,089,602	TOTALS		1,089,602
C - BILLABLE DRUGS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	PHYSICAL THERAPY	66.00	0
2.00		0.00	0	PHARMACY	15.00	0
	TOTALS		0	TOTALS		0
D - BILLABLE SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	PHARMACY	15.00	0
2.00		0.00	0	OPERATING ROOM	50.00	0
3.00		0.00	0	RADIOISOTOPE	56.00	0
4.00		0.00	0	LABORATORY	60.00	0
5.00		0.00	0	PHYSICAL THERAPY	66.00	0
6.00		0.00	0	IMPL. DEV. CHARGED TO PATIENTS	72.00	0
	TOTALS		0	TOTALS		0
E - RENT AND LEASES						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	ADMINISTRATIVE	5.04	0
3.00	COMMUNICATIONS	5.01	0	OTHER ADMINISTRATIVE AND GENERAL	5.06	0
4.00		0.00	0	OPERATION OF PLANT	7.00	0
5.00		0.00	0	HOUSEKEEPING	9.00	0
6.00		0.00	0	DIETARY	10.00	0
7.00		0.00	0	NURSING ADMINISTRATION	13.00	0
8.00		0.00	0	CENTRAL SERVICES & SUPPLY	14.00	0
9.00		0.00	0	PHARMACY	15.00	0
10.00		0.00	0	MEDICAL RECORDS & LIBRARY	16.00	0
11.00		0.00	0	SOCIAL SERVICE	17.00	0
12.00		0.00	0	ADULTS & PEDIATRICS	30.00	0
13.00		0.00	0	INTENSIVE CARE UNIT	31.00	0
14.00		0.00	0	SUBPROVIDER - IPF	40.00	0
15.00		0.00	0	OPERATING ROOM	50.00	0
16.00		0.00	0	ANESTHESIOLOGY	53.00	0
17.00		0.00	0	RADIOLOGY-DIAGNOSTIC	54.00	0
18.00		0.00	0	MRI	58.00	0
19.00		0.00	0	CARDIAC CATHETERIZATION	59.00	0
20.00		0.00	0	LABORATORY	60.00	0
21.00		0.00	0	RESPIRATORY THERAPY	65.00	0
22.00		0.00	0	PHYSICAL THERAPY	66.00	0
23.00		0.00	0	ELECTROCARDIOLOGY	69.00	0
24.00		0.00	0	CLINIC	90.00	0
25.00		0.00	0	EMERGENCY	91.00	0
	TOTALS		0	TOTALS		0
F - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	OTHER ADMINISTRATIVE AND GENERAL	5.06	0
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	INTEREST EXPENSE	113.00	0
	TOTALS		0	TOTALS		0
G - PSYCH						
1.00	ADULTS & PEDIATRICS	30.00	301,648	ADULTS & PEDIATRICS	30.00	0
2.00	SUBPROVIDER - IPF	40.00	0	SUBPROVIDER - IPF	40.00	301,648
	TOTALS		301,648	TOTALS		301,648
H - CNO						
1.00	NURSING ADMINISTRATION	13.00	163,703	OTHER ADMINISTRATIVE AND GENERAL	5.06	163,703
	TOTALS		163,703	TOTALS		163,703
I - RECRUITMENT BONUS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	2,905	EMPLOYEE BENEFITS DEPARTMENT	4.00	0
2.00	HOUSEKEEPING	9.00	200	HOUSEKEEPING	9.00	0
3.00	MEDICAL RECORDS & LIBRARY	16.00	48	MEDICAL RECORDS & LIBRARY	16.00	0
4.00	ADULTS & PEDIATRICS	30.00	438	ADULTS & PEDIATRICS	30.00	0
5.00	OPERATING ROOM	50.00	115	OPERATING ROOM	50.00	0
	TOTALS		3,706	TOTALS		0
J - INSURANCE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	OTHER ADMINISTRATIVE AND GENERAL	5.06	0
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0		0.00	0
	TOTALS		0	TOTALS		0

RECLASSIFICATIONS

Provider CCN: 140292

Period:
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Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
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Increases			Decreases			
Cost Center	Line #	Salary	Cost Center	Line #	Salary	
2.00	3.00	4.00	6.00	7.00	8.00	
K - OP PHARMACY						
1.00	OP PHARMACY	192.03	132,769	PHARMACY	15.00	132,769
	TOTALS		132,769	TOTALS		132,769
L - PROPERTY TAX						
1.00	INTEREST EXPENSE	113.00	0	CAP REL COSTS-BLDG & FIXT	1.00	0
	TOTALS		0	TOTALS		0
M - SHARED SERVICES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	54,047	OTHER ADMINISTRATIVE AND GENERAL	5.06	2,194,967
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	1,696,097	OTHER ADMINISTRATIVE AND GENERAL	5.06	0
3.00	OPERATION OF PLANT	7.00	67,493		0.00	0
4.00	CENTRAL SERVICES & SUPPLY	14.00	63,430		0.00	0
5.00	NURSING ADMINISTRATION	13.00	71,567		0.00	0
6.00	PHARMACY	15.00	11,477		0.00	0
7.00	MEDICAL RECORDS & LIBRARY	16.00	159,134		0.00	0
8.00	LABORATORY	60.00	71,722		0.00	0
9.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	213,522		0.00	0
	TOTALS		2,408,489	TOTALS		2,194,967
N - INTEREST						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	INTEREST EXPENSE	113.00	0
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0		0.00	0
	TOTALS		0	TOTALS		0
500.00	Grand Total: Increases		4,739,188	Grand Total: Decreases		4,521,960

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140292

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

Worksheet A-7
Part I
Date/Time Prepared:
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		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,869,112	0	0	0	0	1.00
2.00	Land Improvements	78,294	0	0	0	0	2.00
3.00	Buildings and Fixtures	25,007,395	45,458	0	45,458	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	7,211,232	4,750	0	4,750	0	5.00
6.00	Movable Equipment	10,309,206	1,641,997	0	1,641,997	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	44,475,239	1,692,205	0	1,692,205	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	44,475,239	1,692,205	0	1,692,205	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,869,112	0				1.00
2.00	Land Improvements	78,294	0				2.00
3.00	Buildings and Fixtures	25,052,853	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	7,215,982	0				5.00
6.00	Movable Equipment	11,951,203	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	46,167,444	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	46,167,444	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140292

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

Worksheet A-7
Part II
Date/Time Prepared:
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Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140292

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

Worksheet A-7
Part III
Date/Time Prepared:
5/27/2014 7:21 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	34,216,241	0	34,216,241	0.741134	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,951,203	0	11,951,203	0.258866	0	2.00
3.00	Total (sum of lines 1-2)	46,167,444	0	46,167,444	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,162,557	253,058	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,646,300	886,978	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,808,857	1,140,036	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	1,112,271	45,791	0	0	2,573,677	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	140,285	3,000	0	0	2,676,563	2.00
3.00	Total (sum of lines 1-2)	1,252,556	48,791	0	0	5,250,240	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140292

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

Worksheet A-8

Date/Time Prepared:
5/27/2014 7:21 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-857,230	CAP REL COSTS-BLDG & FIXT	1.00	11 1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-108,118	CAP REL COSTS-MVBLE EQUIP	2.00	11 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)	A	-81,211	COMMUNICATIONS	5.01	0 7.00
8.00 Television and radio service (chapter 21)	A	-17,253	OPERATION OF PLANT	7.00	0 8.00
9.00 Parking lot (chapter 21)		0		0.00	0 9.00
10.00 Provider-based physician adjustment	A-8-2	-1,481,664			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	567,796			0 12.00
13.00 Laundry and linen service		0		0.00	0 13.00
14.00 Cafeteria-employees and guests		0		0.00	0 14.00
15.00 Rental of quarters to employee and others		0		0.00	0 15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0 16.00
17.00 Sale of drugs to other than patients		0		0.00	0 17.00
18.00 Sale of medical records and abstracts		0		0.00	0 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0 19.00
20.00 Vending machines		0		0.00	0 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0 26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0 27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	28.00
29.00 Physicians' assistant		0		0.00	0 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00	30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00	30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0 32.00
33.00 MISC REVENUE	B	-867,512	OTHER ADMINISTRATIVE AND GENERAL	5.06	0 33.00

Provider CCN: 140292

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

Worksheet A-8

Date/Time Prepared:
5/27/2014 7:21 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
33.01	MISC REVENUE	B	-613	OPERATION OF PLANT	7.00	0 33.01
33.02	MISC REVENUE	B	-112,528	DIETARY	10.00	0 33.02
33.03	MISC REVENUE	B	-10,165	MEDICAL RECORDS & LIBRARY	16.00	0 33.03
33.04	MISC REVENUE	B	-50	SUBPROVIDER - IPF	40.00	0 33.04
33.05	MISC REVENUE	B	-2,444	RADIOLOGY-DIAGNOSTIC	54.00	0 33.05
33.06	MISC REVENUE	B	-2,003	CARDIAC CATHETERIZATION	59.00	0 33.06
33.07	MISC REVENUE	B	-43	PHYSICAL THERAPY	66.00	0 33.07
33.08	MISC REVENUE	B	-681	DRUGS CHARGED TO PATIENTS	73.00	0 33.08
33.09	MISC REVENUE	B	-48,426	CLINIC	90.00	0 33.09
33.10	MISC REVENUE	B	-18,585	EMERGENCY	91.00	0 33.10
33.11	BAD DEBT	A	-3,917,589	OTHER ADMINISTRATIVE AND GENERAL	5.06	0 33.11
33.12	ADVERTISING	A	-269	OTHER ADMINISTRATIVE AND GENERAL	5.06	0 33.12
33.13	PHYSICIAN TRAVEL	A	-1,642	OTHER ADMINISTRATIVE AND GENERAL	5.06	0 33.13
33.14	PHYSICIAN RECRUITMENT	A	-29,441	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.14
33.15	PHYSICIAN COLLECTIONS	A	-30,905	ELECTROCARDIOLOGY	69.00	0 33.15
33.16	OTHER FEES	A	-2,945	OTHER ADMINISTRATIVE AND GENERAL	5.06	0 33.16
33.17	PHYSICIAN MALPRACTICE	A	-524,830	OTHER ADMINISTRATIVE AND GENERAL	5.06	0 33.17
33.18	PROPERTY TAXES	A	1,553,064	CAP REL COSTS-BLDG & FIXT	1.00	13 33.18
33.19	LOBBYING	A	-27,962	OTHER ADMINISTRATIVE AND GENERAL	5.06	0 33.19
33.20	LEGAL	A	-141,116	OTHER ADMINISTRATIVE AND GENERAL	5.06	0 33.20
35.00	NON ALLOWABLE INTEREST	A	-732,392	INTEREST EXPENSE	113.00	0 35.00
37.00			0		0.00	0 37.00
38.00			0		0.00	0 38.00
39.00			0		0.00	0 39.00
41.00			0		0.00	0 41.00
42.00			0		0.00	0 42.00
43.00			0		0.00	0 43.00
44.00			0		0.00	0 44.00
45.00			0		0.00	0 45.00
46.00			0		0.00	0 46.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,896,757			50.00

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

Provider CCN: 140292

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

Worksheet A-8-1

Date/Time Prepared: 5/27/2014 7:21 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	AHS SHARED SERVICES	297,958	0
2.00	5.06	OTHER ADMINISTRATIVE AND GEN	AHS SHARED SERVICES	3,254,501	4,628,840
3.00	7.00	OPERATION OF PLANT	AHS SHARED SERVICES	252,811	0
4.00	13.00	NURSING ADMINISTRATION	AHS SHARED SERVICES	77,927	0
4.01	14.00	CENTRAL SERVICES & SUPPLY	AHS SHARED SERVICES	117,853	0
4.02	15.00	PHARMACY	AHS SHARED SERVICES	12,764	0
4.03	16.00	MEDICAL RECORDS & LIBRARY	AHS SHARED SERVICES	257,656	0
4.04	60.00	LABORATORY	AHS SHARED SERVICES	123,373	0
4.05	71.00	MEDICAL SUPPLIES CHARGED TO	AHS HOME OFFICE	-351,776	0
4.06	1.00	CAP REL COSTS-BLDG & FIXT	AHS HOME OFFICE	69,714	0
4.07	2.00	CAP REL COSTS-MVBLE EQUIP	AHS HOME OFFICE	228,448	0
4.08	4.00	EMPLOYEE BENEFITS DEPARTMENT	AHS HOME OFFICE	247,492	36,347
4.09	5.06	OTHER ADMINISTRATIVE AND GEN	AHS HOME OFFICE	4,322,697	5,596,717
4.10	16.00	MEDICAL RECORDS & LIBRARY	AHS HOME OFFICE	4,274	2,537
4.11	113.00	INTEREST EXPENSE	AHS HOME OFFICE	2,916,966	1,000,421
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			11,832,658	11,264,862

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

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

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

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

6.00	B	AHS CORPORATE	100.00	AHS CORPORATE	0.00	6.00
7.00	B	SHARED SERVICE	0.00	SHARED SERVICE	0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 140292

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

Worksheet A-8-1

Date/Time Prepared:
5/27/2014 7:21 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	297,958	0		1.00
2.00	-1,374,339	0		2.00
3.00	252,811	0		3.00
4.00	77,927	0		4.00
4.01	117,853	0		4.01
4.02	12,764	0		4.02
4.03	257,656	0		4.03
4.04	123,373	0		4.04
4.05	-351,776	0		4.05
4.06	69,714	9		4.06
4.07	228,448	9		4.07
4.08	211,145	0		4.08
4.09	-1,274,020	0		4.09
4.10	1,737	0		4.10
4.11	1,916,545	0		4.11
5.00	567,796			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	MANAGEMENT SVCS		6.00
7.00	FINANCIAL SVCS		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: 140292

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

Worksheet A-8-2

Date/Time Prepared:
5/27/2014 7:21 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	123,750	123,750	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	422,250	422,250	0	0	0	2.00
3.00	59.00	CARDIAC CATHETERIZATION	96,045	96,045	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	42,756	42,756	0	0	0	4.00
5.00	91.00	EMERGENCY	251,213	251,213	0	0	0	5.00
6.00	91.00	EMERGENCY	177,000	177,000	0	0	0	6.00
7.00	91.00	EMERGENCY	237,650	237,650	0	0	0	7.00
8.00	91.00	EMERGENCY	21,500	21,500	0	0	0	8.00
9.00	91.00	EMERGENCY	109,500	109,500	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,481,664	1,481,664	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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	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	30.00	ADULTS & PEDIATRICS	0	0	0	123,750		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	422,250		2.00
3.00	59.00	CARDIAC CATHETERIZATION	0	0	0	96,045		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	42,756		4.00
5.00	91.00	EMERGENCY	0	0	0	251,213		5.00
6.00	91.00	EMERGENCY	0	0	0	177,000		6.00
7.00	91.00	EMERGENCY	0	0	0	237,650		7.00
8.00	91.00	EMERGENCY	0	0	0	21,500		8.00
9.00	91.00	EMERGENCY	0	0	0	109,500		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,481,664		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140292

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

Worksheet B
Part I
Date/Time Prepared:
5/27/2014 7:21 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,573,677	2,573,677			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	2,676,563		2,676,563		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	5,700,143	8,556	8,898	5,717,597	4.00
5.01 00510	COMMUNICATIONS	227,323	4,157	4,324	0	235,804 5.01
5.04 00513	ADMINITTING	1,242,187	10,178	10,585	114,607	0 5.04
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	11,644,369	82,682	85,988	580,066	172,584 5.06
7.00 00700	OPERATION OF PLANT	3,055,492	254,344	264,511	149,907	0 7.00
9.00 00900	HOUSEKEEPING	1,256,578	15,025	15,626	116,554	0 9.00
10.00 01000	DIETARY	358,928	67,398	70,093	42,085	0 10.00
11.00 01100	CAFETERIA	1,114,288	56,220	58,467	99,130	0 11.00
13.00 01300	NURSING ADMINISTRATION	1,365,609	22,374	23,269	166,892	0 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	492,356	74,816	77,807	56,921	0 14.00
15.00 01500	PHARMACY	1,432,364	27,015	28,094	203,196	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,043,330	16,681	17,348	91,245	0 16.00
17.00 01700	SOCIAL SERVICE	1,077,718	7,418	7,714	106,846	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	9,474,150	611,123	635,552	1,286,261	51,222 30.00
31.00 03100	INTENSIVE CARE UNIT	2,270,649	84,942	88,338	294,924	4,615 31.00
40.00 04000	SUBPROVIDER - IPF	2,123,886	102,210	106,296	279,489	7,383 40.00
43.00 04300	NURSERY	534,074	66,829	69,501	60,576	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,704,968	167,090	173,769	202,310	0 50.00
51.00 05100	RECOVERY ROOM	309,699	10,350	10,764	43,905	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	955,595	68,468	71,205	108,385	0 52.00
53.00 05300	ANESTHESIOLOGY	92,267	7,245	7,535	7,066	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,056,440	44,455	46,232	127,757	0 54.00
56.00 05600	RADIOISOTOPE	177,973	18,803	19,555	23,934	0 56.00
57.00 05700	CT SCAN	438,091	46,042	47,883	61,133	0 57.00
58.00 05800	MRI	170,688	22,909	23,825	23,661	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	805,508	46,784	48,654	78,657	0 59.00
60.00 06000	LABORATORY	2,469,342	63,551	66,092	207,091	0 60.00
65.00 06500	RESPIRATORY THERAPY	837,067	7,970	8,288	101,583	0 65.00
66.00 06600	PHYSICAL THERAPY	513,750	14,646	15,231	35,131	0 66.00
67.00 06700	OCCUPATIONAL THERAPY	85,466	1,449	1,507	8,295	0 67.00
68.00 06800	SPEECH PATHOLOGY	24,115	949	987	2,955	0 68.00
69.00 06900	ELECTROCARDIOLOGY	411,240	36,433	37,890	54,644	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	32,605	4,865	5,059	2,336	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,603,233	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	1,760,550	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,882,647	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	147,970	0	0	0	0 74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	180,116	68,951	71,707	30,679	0 90.00
91.00 09100	EMERGENCY	2,416,426	333,938	347,288	318,324	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	67,739,440	2,476,866	2,575,882	5,086,545	235,804 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	53,664	4,744	4,934	6,076	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	6,765,965	0	0	25,583	0 192.00
192.03 19203	OP PHARMACY	353,570	6,038	6,279	20,588	0 192.03
194.00 07950	FOUNDATION	126,135	3,088	3,211	16,519	0 194.00
194.01 07951	MARKETING	308,124	4,106	4,270	17,953	0 194.01
194.03 07953	THERAPEUTIC DAY SCHOOL	4,792,664	78,835	81,987	544,333	0 194.03
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	80,139,562	2,573,677	2,676,563	5,717,597	235,804 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140292

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

Worksheet B Part I Date/Time Prepared: 5/27/2014 7:21 pm

Cost Center Description		ADMINITTING	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	HOUSEKEEPING	
		5.04	5A.04	5.06	7.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	COMMUNICATIONS					5.01
5.04	00513	ADMINITTING	1,377,557				5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	0	12,565,689	12,565,689		5.06
7.00	00700	OPERATION OF PLANT	0	3,724,254	692,544	4,416,798	7.00
9.00	00900	HOUSEKEEPING	0	1,403,783	261,040	29,978	1,694,801
10.00	01000	DIETARY	0	538,504	100,138	134,470	51,951
11.00	01100	CAFETERIA	0	1,328,105	246,968	112,168	43,335
13.00	01300	NURSING ADMINISTRATION	0	1,578,144	293,464	44,640	17,246
14.00	01400	CENTRAL SERVICES & SUPPLY	0	701,900	130,522	149,270	57,669
15.00	01500	PHARMACY	0	1,690,669	314,388	53,898	20,823
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,168,604	217,308	33,282	12,858
17.00	01700	SOCIAL SERVICE	0	1,199,696	223,089	14,800	5,718
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	194,751	12,253,059	2,278,505	1,219,284	471,057
31.00	03100	INTENSIVE CARE UNIT	31,745	2,775,213	516,065	169,473	65,474
40.00	04000	SUBPROVIDER - IPF	44,113	2,663,377	495,268	203,925	78,784
43.00	04300	NURSERY	4,662	735,642	136,796	133,334	51,512
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	88,297	2,336,434	434,472	333,371	128,794
51.00	05100	RECOVERY ROOM	15,935	390,653	72,644	20,651	7,978
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,342	1,211,995	225,377	136,604	52,776
53.00	05300	ANESTHESIOLOGY	25,043	139,156	25,877	14,455	5,585
54.00	05400	RADIOLOGY-DIAGNOSTIC	74,917	1,349,801	251,002	88,695	34,266
56.00	05600	RADIOISOTOPE	17,646	257,911	47,960	37,515	14,494
57.00	05700	CT SCAN	104,337	697,486	129,701	91,861	35,490
58.00	05800	MRI	21,403	262,486	48,811	45,707	17,658
59.00	05900	CARDIAC CATHETERIZATION	40,782	1,020,385	189,746	93,341	36,061
60.00	06000	LABORATORY	189,821	2,995,897	557,102	126,795	48,986
65.00	06500	RESPIRATORY THERAPY	39,927	994,835	184,995	15,901	6,143
66.00	06600	PHYSICAL THERAPY	15,934	594,692	110,586	29,221	11,289
67.00	06700	OCCUPATIONAL THERAPY	2,249	98,966	18,403	2,891	1,117
68.00	06800	SPEECH PATHOLOGY	1,261	30,267	5,628	1,893	731
69.00	06900	ELECTROCARDIOLOGY	41,981	582,188	108,261	72,690	28,083
70.00	07000	ELECTROENCEPHALOGRAPHY	1,085	45,950	8,545	9,706	3,750
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	37,182	1,640,415	305,043	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	48,895	1,809,445	336,475	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	129,258	2,011,905	374,124	0	0
74.00	07400	RENAL DIALYSIS	2,970	150,940	28,068	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	11,363	362,816	67,467	137,568	53,148
91.00	09100	EMERGENCY	183,658	3,599,634	669,370	666,259	257,402
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,377,557	66,910,896	10,105,752	4,223,646	1,620,178
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	69,418	12,909	9,465	3,657
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,791,548	1,262,922	0	0
192.03	19203	OP PHARMACY	0	386,475	71,867	12,046	4,654
194.00	07950	FOUNDATION	0	148,953	27,699	6,161	2,380
194.01	07951	MARKETING	0	334,453	62,193	8,191	3,165
194.03	07953	THERAPEUTIC DAY SCHOOL	0	5,497,819	1,022,347	157,289	60,767
200.00		Cross Foot Adjustments		0			
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,377,557	80,139,562	12,565,689	4,416,798	1,694,801

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140292

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

Worksheet B
Part I
Date/Time Prepared:
5/27/2014 7:21 pm

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
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.04	00513						5.04
5.06	00560						5.06
7.00	00700						7.00
9.00	00900						9.00
10.00	01000	825,063					10.00
11.00	01100	0	1,730,576				11.00
13.00	01300	0	54,047	1,987,541			13.00
14.00	01400	0	57,760	0	1,097,121		14.00
15.00	01500	0	70,756	0	6,811	2,157,345	15.00
16.00	01600	0	48,786	0	0	0	16.00
17.00	01700	0	41,051	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	610,935	562,282	985,816	63,163	527	30.00
31.00	03100	69,590	111,910	196,243	36,297	0	31.00
40.00	04000	144,538	126,504	221,817	11,009	0	40.00
43.00	04300	0	25,940	45,515	3,173	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	82,823	145,234	36,081	1,588	50.00
51.00	05100	0	13,770	24,101	1,396	0	51.00
52.00	05200	0	46,466	81,439	4,140	0	52.00
53.00	05300	0	4,745	8,338	5,212	0	53.00
54.00	05400	0	53,273	0	2,405	109	54.00
56.00	05600	0	7,787	0	323	1,279	56.00
57.00	05700	0	23,155	0	2,439	268	57.00
58.00	05800	0	8,406	0	157	26	58.00
59.00	05900	0	24,032	0	5,077	0	59.00
60.00	06000	0	96,799	0	10,511	0	60.00
65.00	06500	0	46,517	0	5,828	0	65.00
66.00	06600	0	12,996	0	803	5,211	66.00
67.00	06700	0	2,579	0	0	0	67.00
68.00	06800	0	1,031	0	0	0	68.00
69.00	06900	0	24,496	0	1,267	305	69.00
70.00	07000	0	1,392	0	288	0	70.00
71.00	07100	0	0	0	443,010	0	71.00
72.00	07200	0	0	0	408,263	0	72.00
73.00	07300	0	0	0	0	2,140,626	73.00
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	14,079	24,674	3,217	1,448	90.00
91.00	09100	0	145,070	254,364	46,251	5,958	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		825,063	1,708,452	1,987,541	1,097,121	2,157,345	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	4,538	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.03	19203	0	5,106	0	0	0	192.03
194.00	07950	0	4,641	0	0	0	194.00
194.01	07951	0	7,839	0	0	0	194.01
194.03	07953	0	0	0	0	0	194.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		825,063	1,730,576	1,987,541	1,097,121	2,157,345	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140292

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

Worksheet B
Part I
Date/Time Prepared:
5/27/2014 7:21 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	COMMUNICATIONS					5.01
5.04	00513	ADMINISTRATIVE					5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL					5.06
7.00	00700	OPERATION OF PLANT					7.00
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	1,480,838				16.00
17.00	01700	SOCIAL SERVICE	0	1,484,354			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	209,429	1,064,808	19,718,865	0	19,718,865
31.00	03100	INTENSIVE CARE UNIT	34,123	121,284	4,095,672	0	4,095,672
40.00	04000	SUBPROVIDER - IPF	47,417	251,923	4,244,562	0	4,244,562
43.00	04300	NURSERY	5,011	42,224	1,179,147	0	1,179,147
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	94,911	0	3,593,708	0	3,593,708
51.00	05100	RECOVERY ROOM	17,129	0	548,322	0	548,322
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,967	4,115	1,771,879	0	1,771,879
53.00	05300	ANESTHESIOLOGY	26,919	0	230,287	0	230,287
54.00	05400	RADIOLOGY-DIAGNOSTIC	80,529	0	1,860,080	0	1,860,080
56.00	05600	RADIOISOTOPE	18,968	0	386,237	0	386,237
57.00	05700	CT SCAN	112,153	0	1,092,553	0	1,092,553
58.00	05800	MRI	23,006	0	406,257	0	406,257
59.00	05900	CARDIAC CATHETERIZATION	43,837	0	1,412,479	0	1,412,479
60.00	06000	LABORATORY	204,041	0	4,040,131	0	4,040,131
65.00	06500	RESPIRATORY THERAPY	42,918	0	1,297,137	0	1,297,137
66.00	06600	PHYSICAL THERAPY	17,127	0	781,925	0	781,925
67.00	06700	OCCUPATIONAL THERAPY	2,418	0	126,374	0	126,374
68.00	06800	SPEECH PATHOLOGY	1,356	0	40,906	0	40,906
69.00	06900	ELECTROCARDIOLOGY	45,126	0	862,416	0	862,416
70.00	07000	ELECTROENCEPHALOGRAPHY	1,166	0	70,797	0	70,797
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	39,967	0	2,428,435	0	2,428,435
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	52,557	0	2,606,740	0	2,606,740
73.00	07300	DRUGS CHARGED TO PATIENTS	138,941	0	4,665,596	0	4,665,596
74.00	07400	RENAL DIALYSIS	3,192	0	182,200	0	182,200
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	12,214	0	676,631	0	676,631
91.00	09100	EMERGENCY	197,416	0	5,841,724	0	5,841,724
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,480,838	1,484,354	64,161,060	0	64,161,060
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	99,987	0	99,987
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	8,054,470	0	8,054,470
192.03	19203	OP PHARMACY	0	0	480,148	0	480,148
194.00	07950	FOUNDATION	0	0	189,834	0	189,834
194.01	07951	MARKETING	0	0	415,841	0	415,841
194.03	07953	THERAPEUTIC DAY SCHOOL	0	0	6,738,222	0	6,738,222
200.00		Cross Foot Adjustments			0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,480,838	1,484,354	80,139,562	0	80,139,562

COST ALLOCATION STATISTICS

Provider CCN: 140292

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

Worksheet Non-CMS W
Date/Time Prepared:
5/27/2014 7:21 pm

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.01	COMMUNICATIONS	2	NUMBER OF PHONES	5.01
5.04	ADMITTING	C	GROSS CHARGES	5.04
5.06	OTHER ADMINISTRATIVE AND GENERAL	-1	ACCUM. COST	5.06
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	3	MEALS SERVED	10.00
11.00	CAFETERIA	4	HOURS WORKED	11.00
13.00	NURSING ADMINISTRATION	5	DIRECT NRSING	13.00
14.00	CENTRAL SERVICES & SUPPLY	6	COSTED REQUIS.	14.00
15.00	PHARMACY	7	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS CHARGES	16.00
17.00	SOCIAL SERVICE	8	TOTAL PATIENT DAYS	17.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140292

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

Worksheet B
Part II
Date/Time Prepared:
5/27/2014 7:21 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,556	8,898	17,454	4.00
5.01 00510	COMMUNICATIONS	0	4,157	4,324	8,481	5.01
5.04 00513	ADMINISTRATIVE	0	10,178	10,585	20,763	5.04
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	0	82,682	85,988	168,670	5.06
7.00 00700	OPERATION OF PLANT	0	254,344	264,511	518,855	7.00
9.00 00900	HOUSEKEEPING	0	15,025	15,626	30,651	9.00
10.00 01000	DIETARY	0	67,398	70,093	137,491	10.00
11.00 01100	CAFETERIA	0	56,220	58,467	114,687	11.00
13.00 01300	NURSING ADMINISTRATION	0	22,374	23,269	45,643	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	74,816	77,807	152,623	14.00
15.00 01500	PHARMACY	0	27,015	28,094	55,109	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	16,681	17,348	34,029	16.00
17.00 01700	SOCIAL SERVICE	0	7,418	7,714	15,132	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	611,123	635,552	1,246,675	30.00
31.00 03100	INTENSIVE CARE UNIT	0	84,942	88,338	173,280	31.00
40.00 04000	SUBPROVIDER - IPF	0	102,210	106,296	208,506	40.00
43.00 04300	NURSERY	0	66,829	69,501	136,330	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	167,090	173,769	340,859	50.00
51.00 05100	RECOVERY ROOM	0	10,350	10,764	21,114	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	68,468	71,205	139,673	52.00
53.00 05300	ANESTHESIOLOGY	0	7,245	7,535	14,780	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	44,455	46,232	90,687	54.00
56.00 05600	RADIOISOTOPE	0	18,803	19,555	38,358	56.00
57.00 05700	CT SCAN	0	46,042	47,883	93,925	57.00
58.00 05800	MRI	0	22,909	23,825	46,734	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	46,784	48,654	95,438	59.00
60.00 06000	LABORATORY	0	63,551	66,092	129,643	60.00
65.00 06500	RESPIRATORY THERAPY	0	7,970	8,288	16,258	65.00
66.00 06600	PHYSICAL THERAPY	0	14,646	15,231	29,877	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	1,449	1,507	2,956	67.00
68.00 06800	SPEECH PATHOLOGY	0	949	987	1,936	68.00
69.00 06900	ELECTROCARDIOLOGY	0	36,433	37,890	74,323	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	4,865	5,059	9,924	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	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
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	68,951	71,707	140,658	90.00
91.00 09100	EMERGENCY	0	333,938	347,288	681,226	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	2,476,866	2,575,882	5,052,748	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,744	4,934	9,678	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.03 19203	OP PHARMACY	0	6,038	6,279	12,317	192.03
194.00 07950	FOUNDATION	0	3,088	3,211	6,299	194.00
194.01 07951	MARKETING	0	4,106	4,270	8,376	194.01
194.03 07953	THERAPEUTIC DAY SCHOOL	0	78,835	81,987	160,822	194.03
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	2,573,677	2,676,563	5,250,240	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 5/27/2014 7:21 pm				
Cost Center Description		COMMUNICATIONS	ADMINITTING	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	HOUSEKEEPING		
		5.01	5.04	5.06	7.00	9.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	00510	COMMUNICATIONS	8,481				5.01	
5.04	00513	ADMINITTING	0	21,113			5.04	
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	6,207	0	176,646		5.06	
7.00	00700	OPERATION OF PLANT	0	0	9,735	529,047	7.00	
9.00	00900	HOUSEKEEPING	0	0	3,669	3,591	38,267	9.00
10.00	01000	DIETARY	0	0	1,408	16,107	1,173	10.00
11.00	01100	CAFETERIA	0	0	3,472	13,435	978	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	4,125	5,347	389	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,835	17,880	1,302	14.00
15.00	01500	PHARMACY	0	0	4,419	6,456	470	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	3,055	3,987	290	16.00
17.00	01700	SOCIAL SERVICE	0	0	3,136	1,773	129	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,842	2,906	32,042	146,044	10,637	30.00
31.00	03100	INTENSIVE CARE UNIT	166	489	7,254	20,300	1,478	31.00
40.00	04000	SUBPROVIDER - IPF	266	679	6,962	24,426	1,779	40.00
43.00	04300	NURSERY	0	72	1,923	15,971	1,163	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,359	6,107	39,931	2,908	50.00
51.00	05100	RECOVERY ROOM	0	245	1,021	2,474	180	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	128	3,168	16,363	1,192	52.00
53.00	05300	ANESTHESIOLOGY	0	385	364	1,731	126	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,153	3,528	10,624	774	54.00
56.00	05600	RADIOISOTOPE	0	272	674	4,494	327	56.00
57.00	05700	CT SCAN	0	1,606	1,823	11,003	801	57.00
58.00	05800	MRI	0	329	686	5,475	399	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	628	2,667	11,180	814	59.00
60.00	06000	LABORATORY	0	2,922	7,831	15,188	1,106	60.00
65.00	06500	RESPIRATORY THERAPY	0	615	2,600	1,905	139	65.00
66.00	06600	PHYSICAL THERAPY	0	245	1,555	3,500	255	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	35	259	346	25	67.00
68.00	06800	SPEECH PATHOLOGY	0	19	79	227	17	68.00
69.00	06900	ELECTROCARDIOLOGY	0	646	1,522	8,707	634	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	17	120	1,163	85	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	572	4,288	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	753	4,730	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,990	5,259	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	46	395	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	175	948	16,478	1,200	90.00
91.00	09100	EMERGENCY	0	2,827	9,409	79,805	5,812	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,481	21,113	142,068	505,911	36,582	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	181	1,134	83	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	17,753	0	0	192.00
192.03	19203	OP PHARMACY	0	0	1,010	1,443	105	192.03
194.00	07950	FOUNDATION	0	0	389	738	54	194.00
194.01	07951	MARKETING	0	0	874	981	71	194.01
194.03	07953	THERAPEUTIC DAY SCHOOL	0	0	14,371	18,840	1,372	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	8,481	21,113	176,646	529,047	38,267	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 5/27/2014 7:21 pm
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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
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.04	00513						5.04
5.06	00560						5.06
7.00	00700						7.00
9.00	00900						9.00
10.00	01000	156,307					10.00
11.00	01100	0	132,874				11.00
13.00	01300	0	4,150	60,163			13.00
14.00	01400	0	4,435	0	178,249		14.00
15.00	01500	0	5,433	0	1,107	73,614	15.00
16.00	01600	0	3,746	0	0	0	16.00
17.00	01700	0	3,152	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	115,741	43,173	29,841	10,262	18	30.00
31.00	03100	13,184	8,592	5,940	5,897	0	31.00
40.00	04000	27,382	9,713	6,714	1,789	0	40.00
43.00	04300	0	1,992	1,378	516	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	6,359	4,396	5,862	54	50.00
51.00	05100	0	1,057	730	227	0	51.00
52.00	05200	0	3,568	2,465	673	0	52.00
53.00	05300	0	364	252	847	0	53.00
54.00	05400	0	4,090	0	391	4	54.00
56.00	05600	0	598	0	52	44	56.00
57.00	05700	0	1,778	0	396	9	57.00
58.00	05800	0	645	0	25	1	58.00
59.00	05900	0	1,845	0	825	0	59.00
60.00	06000	0	7,432	0	1,708	0	60.00
65.00	06500	0	3,572	0	947	0	65.00
66.00	06600	0	998	0	130	178	66.00
67.00	06700	0	198	0	0	0	67.00
68.00	06800	0	79	0	0	0	68.00
69.00	06900	0	1,881	0	206	10	69.00
70.00	07000	0	107	0	47	0	70.00
71.00	07100	0	0	0	71,975	0	71.00
72.00	07200	0	0	0	66,330	0	72.00
73.00	07300	0	0	0	0	73,044	73.00
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	1,081	747	523	49	90.00
91.00	09100	0	11,138	7,700	7,514	203	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		156,307	131,176	60,163	178,249	73,614	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	348	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.03	19203	0	392	0	0	0	192.03
194.00	07950	0	356	0	0	0	194.00
194.01	07951	0	602	0	0	0	194.01
194.03	07953	0	0	0	0	0	194.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		156,307	132,874	60,163	178,249	73,614	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140292

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

Worksheet B
Part II
Date/Time Prepared:
5/27/2014 7:21 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	COMMUNICATIONS					5.01
5.04	00513	ADMITTING					5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL					5.06
7.00	00700	OPERATION OF PLANT					7.00
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	45,385				16.00
17.00	01700	SOCIAL SERVICE	0	23,648			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,342	16,963	1,666,421	0	1,666,421
31.00	03100	INTENSIVE CARE UNIT	1,048	1,932	240,460	0	240,460
40.00	04000	SUBPROVIDER - IPF	1,456	4,014	294,539	0	294,539
43.00	04300	NURSERY	154	673	160,357	0	160,357
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,915	0	411,367	0	411,367
51.00	05100	RECOVERY ROOM	526	0	27,708	0	27,708
52.00	05200	DELIVERY ROOM & LABOR ROOM	275	66	167,902	0	167,902
53.00	05300	ANESTHESIOLOGY	827	0	19,698	0	19,698
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,473	0	114,114	0	114,114
56.00	05600	RADIOISOTOPE	582	0	45,474	0	45,474
57.00	05700	CT SCAN	3,444	0	114,971	0	114,971
58.00	05800	MRI	706	0	55,072	0	55,072
59.00	05900	CARDIAC CATHETERIZATION	1,346	0	114,983	0	114,983
60.00	06000	LABORATORY	6,266	0	172,728	0	172,728
65.00	06500	RESPIRATORY THERAPY	1,318	0	27,664	0	27,664
66.00	06600	PHYSICAL THERAPY	526	0	37,371	0	37,371
67.00	06700	OCCUPATIONAL THERAPY	74	0	3,918	0	3,918
68.00	06800	SPEECH PATHOLOGY	42	0	2,408	0	2,408
69.00	06900	ELECTROCARDIOLOGY	1,386	0	89,482	0	89,482
70.00	07000	ELECTROENCEPHALOGRAPHY	36	0	11,506	0	11,506
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,227	0	78,062	0	78,062
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,614	0	73,427	0	73,427
73.00	07300	DRUGS CHARGED TO PATIENTS	4,267	0	84,560	0	84,560
74.00	07400	RENAL DIALYSIS	98	0	539	0	539
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	375	0	162,328	0	162,328
91.00	09100	EMERGENCY	6,062	0	812,667	0	812,667
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	45,385	23,648	4,989,726	0	4,989,726
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	11,443	0	11,443
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	17,831	0	17,831
192.03	19203	OP PHARMACY	0	0	15,330	0	15,330
194.00	07950	FOUNDATION	0	0	7,886	0	7,886
194.01	07951	MARKETING	0	0	10,959	0	10,959
194.03	07953	THERAPEUTIC DAY SCHOOL	0	0	197,065	0	197,065
200.00		Cross Foot Adjustments			0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	45,385	23,648	5,250,240	0	5,250,240

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140292

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

Worksheet B-1

Date/Time Prepared:
5/27/2014 7:21 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER OF PHONES)	ADMITTING (GROSS CHARGES)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	149,193				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		149,193			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	496	496	36,871,840		4.00
5.01 00510	COMMUNICATIONS	241	241	0	511	5.01
5.04 00513	ADMITTING	590	590	739,082	0	235,618,371
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	4,793	4,793	3,740,744	374	0
7.00 00700	OPERATION OF PLANT	14,744	14,744	966,727	0	0
9.00 00900	HOUSEKEEPING	871	871	751,635	0	0
10.00 01000	DIETARY	3,907	3,907	271,400	0	0
11.00 01100	CAFETERIA	3,259	3,259	639,271	0	0
13.00 01300	NURSING ADMINISTRATION	1,297	1,297	1,076,258	0	0
14.00 01400	CENTRAL SERVICES & SUPPLY	4,337	4,337	367,076	0	0
15.00 01500	PHARMACY	1,566	1,566	1,310,373	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	967	967	588,422	0	0
17.00 01700	SOCIAL SERVICE	430	430	689,033	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	35,426	35,426	8,294,932	111	33,325,782
31.00 03100	INTENSIVE CARE UNIT	4,924	4,924	1,901,913	10	5,429,336
40.00 04000	SUBPROVIDER - IPF	5,925	5,925	1,802,377	16	7,544,516
43.00 04300	NURSERY	3,874	3,874	390,643	0	797,352
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	9,686	9,686	1,304,665	0	15,101,228
51.00 05100	RECOVERY ROOM	600	600	283,134	0	2,725,357
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,969	3,969	698,959	0	1,426,665
53.00 05300	ANESTHESIOLOGY	420	420	45,566	0	4,283,095
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,577	2,577	823,880	0	12,812,945
56.00 05600	RADIOISOTOPE	1,090	1,090	154,345	0	3,017,909
57.00 05700	CT SCAN	2,669	2,669	394,238	0	17,844,521
58.00 05800	MRI	1,328	1,328	152,588	0	3,660,427
59.00 05900	CARDIAC CATHETERIZATION	2,712	2,712	507,244	0	6,974,845
60.00 06000	LABORATORY	3,684	3,684	1,335,491	0	32,464,723
65.00 06500	RESPIRATORY THERAPY	462	462	655,088	0	6,828,690
66.00 06600	PHYSICAL THERAPY	849	849	226,555	0	2,725,111
67.00 06700	OCCUPATIONAL THERAPY	84	84	53,493	0	384,679
68.00 06800	SPEECH PATHOLOGY	55	55	19,056	0	215,696
69.00 06900	ELECTROCARDIOLOGY	2,112	2,112	352,387	0	7,179,878
70.00 07000	ELECTROENCEPHALOGRAPHY	282	282	15,064	0	185,532
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	6,359,184
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	8,362,356
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	22,106,702
74.00 07400	RENAL DIALYSIS	0	0	0	0	507,870
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	3,997	3,997	197,842	0	1,943,331
91.00 09100	EMERGENCY	19,358	19,358	2,052,815	0	31,410,641
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	143,581	143,581	32,802,296	511	235,618,371
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	275	275	39,185	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	164,979	0	0
192.03 19203	OP PHARMACY	350	350	132,769	0	0
194.00 07950	FOUNDATION	179	179	106,531	0	0
194.01 07951	MARKETING	238	238	115,773	0	0
194.03 07953	THERAPEUTIC DAY SCHOOL	4,570	4,570	3,510,307	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	2,573,677	2,676,563	5,717,597	235,804	1,377,557
203.00	Unit cost multiplier (Wkst. B, Part I)	17.250655	17.940272	0.155067	461.455969	0.005847
204.00	Cost to be allocated (per Wkst. B, Part II)			17,454	8,481	21,113
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000473	16.596869	0.000090

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140292

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

Worksheet B-1

Date/Time Prepared:
5/27/2014 7:21 pm

Cost Center Description		Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		5A.06	5.06	7.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	COMMUNICATIONS					5.01
5.04	00513	ADMITTING					5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	-12,565,689	67,573,873			5.06
7.00	00700	OPERATION OF PLANT	0	3,724,254	128,329		7.00
9.00	00900	HOUSEKEEPING	0	1,403,783	871	127,458	9.00
10.00	01000	DIETARY	0	538,504	3,907	3,907	96,567
11.00	01100	CAFETERIA	0	1,328,105	3,259	3,259	0
13.00	01300	NURSING ADMINISTRATION	0	1,578,144	1,297	1,297	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	701,900	4,337	4,337	0
15.00	01500	PHARMACY	0	1,690,669	1,566	1,566	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,168,604	967	967	0
17.00	01700	SOCIAL SERVICE	0	1,199,696	430	430	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	12,253,059	35,426	35,426	71,505
31.00	03100	INTENSIVE CARE UNIT	0	2,775,213	4,924	4,924	8,145
40.00	04000	SUBPROVIDER - IPF	0	2,663,377	5,925	5,925	16,917
43.00	04300	NURSERY	0	735,642	3,874	3,874	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	2,336,434	9,686	9,686	0
51.00	05100	RECOVERY ROOM	0	390,653	600	600	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,211,995	3,969	3,969	0
53.00	05300	ANESTHESIOLOGY	0	139,156	420	420	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,349,801	2,577	2,577	0
56.00	05600	RADIOISOTOPE	0	257,911	1,090	1,090	0
57.00	05700	CT SCAN	0	697,486	2,669	2,669	0
58.00	05800	MRI	0	262,486	1,328	1,328	0
59.00	05900	CARDIAC CATHETERIZATION	0	1,020,385	2,712	2,712	0
60.00	06000	LABORATORY	0	2,995,897	3,684	3,684	0
65.00	06500	RESPIRATORY THERAPY	0	994,835	462	462	0
66.00	06600	PHYSICAL THERAPY	0	594,692	849	849	0
67.00	06700	OCCUPATIONAL THERAPY	0	98,966	84	84	0
68.00	06800	SPEECH PATHOLOGY	0	30,267	55	55	0
69.00	06900	ELECTROCARDIOLOGY	0	582,188	2,112	2,112	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	45,950	282	282	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,640,415	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,809,445	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,011,905	0	0	0
74.00	07400	RENAL DIALYSIS	0	150,940	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	362,816	3,997	3,997	0
91.00	09100	EMERGENCY	0	3,599,634	19,358	19,358	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-12,565,689	54,345,207	122,717	121,846	96,567
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	69,418	275	275	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,791,548	0	0	0
192.03	19203	OP PHARMACY	0	386,475	350	350	0
194.00	07950	FOUNDATION	0	148,953	179	179	0
194.01	07951	MARKETING	0	334,453	238	238	0
194.03	07953	THERAPEUTIC DAY SCHOOL	0	5,497,819	4,570	4,570	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	12,565,689	4,416,798	1,694,801	825,063	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.185955	34.417770	13.296937	8.543944	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	176,646	529,047	38,267	156,307	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.002614	4.122583	0.300232	1.618638	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140292

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

Worksheet B-1
Date/Time Prepared: 5/27/2014 7:21 pm

Cost Center Description		CAFETERIA (HOURS WORKED)	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.04	00513						5.04
5.06	00560						5.06
7.00	00700						7.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	33,557					11.00
13.00	01300	1,048	457,206				13.00
14.00	01400	1,120	0	4,731,115			14.00
15.00	01500	1,372	0	29,372	1,898,039		15.00
16.00	01600	946	0	0	0	235,618,371	16.00
17.00	01700	796	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	10,903	226,773	272,379	464	33,325,782	30.00
31.00	03100	2,170	45,143	156,524	0	5,429,336	31.00
40.00	04000	2,453	51,026	47,472	0	7,544,516	40.00
43.00	04300	503	10,470	13,684	0	797,352	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,606	33,409	155,591	1,397	15,101,228	50.00
51.00	05100	267	5,544	6,018	0	2,725,357	51.00
52.00	05200	901	18,734	17,852	0	1,426,665	52.00
53.00	05300	92	1,918	22,475	0	4,283,095	53.00
54.00	05400	1,033	0	10,370	96	12,812,945	54.00
56.00	05600	151	0	1,393	1,125	3,017,909	56.00
57.00	05700	449	0	10,518	236	17,844,521	57.00
58.00	05800	163	0	675	23	3,660,427	58.00
59.00	05900	466	0	21,894	0	6,974,845	59.00
60.00	06000	1,877	0	45,328	0	32,464,723	60.00
65.00	06500	902	0	25,132	0	6,828,690	65.00
66.00	06600	252	0	3,462	4,585	2,725,111	66.00
67.00	06700	50	0	0	0	384,679	67.00
68.00	06800	20	0	0	0	215,696	68.00
69.00	06900	475	0	5,462	268	7,179,878	69.00
70.00	07000	27	0	1,240	0	185,532	70.00
71.00	07100	0	0	1,910,407	0	6,359,184	71.00
72.00	07200	0	0	1,760,550	0	8,362,356	72.00
73.00	07300	0	0	0	1,883,329	22,106,702	73.00
74.00	07400	0	0	0	0	507,870	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	273	5,676	13,871	1,274	1,943,331	90.00
91.00	09100	2,813	58,513	199,446	5,242	31,410,641	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00							118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	88	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.03	19203	99	0	0	0	0	192.03
194.00	07950	90	0	0	0	0	194.00
194.01	07951	152	0	0	0	0	194.01
194.03	07953	0	0	0	0	0	194.03
200.00							200.00
201.00							201.00
202.00		1,730,576	1,987,541	1,097,121	2,157,345	1,480,838	202.00
203.00		51.571237	4.347145	0.231895	1.136618	0.006285	203.00
204.00		132,874	60,163	178,249	73,614	45,385	204.00
205.00		3.959651	0.131588	0.037676	0.038784	0.000193	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140292

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

Worksheet C
Part I
Date/Time Prepared:
5/27/2014 7:21 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE	Total Costs	
					Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	19,718,865		19,718,865	0	19,718,865	30.00
31.00	03100 INTENSIVE CARE UNIT	4,095,672		4,095,672	0	4,095,672	31.00
40.00	04000 SUBPROVIDER - I/PF	4,244,562		4,244,562	0	4,244,562	40.00
43.00	04300 NURSERY	1,179,147		1,179,147	0	1,179,147	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	3,593,708		3,593,708	0	3,593,708	50.00
51.00	05100 RECOVERY ROOM	548,322		548,322	0	548,322	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,771,879		1,771,879	0	1,771,879	52.00
53.00	05300 ANESTHESIOLOGY	230,287		230,287	0	230,287	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,860,080		1,860,080	0	1,860,080	54.00
56.00	05600 RADIOISOTOPE	386,237		386,237	0	386,237	56.00
57.00	05700 CT SCAN	1,092,553		1,092,553	0	1,092,553	57.00
58.00	05800 MRI	406,257		406,257	0	406,257	58.00
59.00	05900 CARDIAC CATHETERIZATION	1,412,479		1,412,479	0	1,412,479	59.00
60.00	06000 LABORATORY	4,040,131		4,040,131	0	4,040,131	60.00
65.00	06500 RESPIRATORY THERAPY	1,297,137	0	1,297,137	0	1,297,137	65.00
66.00	06600 PHYSICAL THERAPY	781,925	0	781,925	0	781,925	66.00
67.00	06700 OCCUPATIONAL THERAPY	126,374	0	126,374	0	126,374	67.00
68.00	06800 SPEECH PATHOLOGY	40,906	0	40,906	0	40,906	68.00
69.00	06900 ELECTROCARDIOLOGY	862,416		862,416	0	862,416	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	70,797		70,797	0	70,797	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,428,435		2,428,435	0	2,428,435	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2,606,740		2,606,740	0	2,606,740	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,665,596		4,665,596	0	4,665,596	73.00
74.00	07400 RENAL DIALYSIS	182,200		182,200	0	182,200	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	676,631		676,631	0	676,631	90.00
91.00	09100 EMERGENCY	5,841,724		5,841,724	0	5,841,724	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,244,104		1,244,104	0	1,244,104	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	65,405,164	0	65,405,164	0	65,405,164	200.00
201.00	Less Observation Beds	1,244,104		1,244,104		1,244,104	201.00
202.00	Total (see instructions)	64,161,060	0	64,161,060	0	64,161,060	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140292

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

Worksheet C
Part I
Date/Time Prepared:
5/27/2014 7:21 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title VIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	30,588,868		30,588,868		30.00
31.00	03100	INTENSIVE CARE UNIT	5,429,336		5,429,336		31.00
40.00	04000	SUBPROVIDER - IPF	7,544,516		7,544,516		40.00
43.00	04300	NURSERY	797,352		797,352		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,050,663	9,050,565	15,101,228	0.237975	50.00
51.00	05100	RECOVERY ROOM	889,765	1,835,592	2,725,357	0.201193	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,276,881	149,784	1,426,665	1.241973	52.00
53.00	05300	ANESTHESIOLOGY	1,780,281	2,502,814	4,283,095	0.053766	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,732,299	9,080,646	12,812,945	0.145172	54.00
56.00	05600	RADIOISOTOPE	1,294,118	1,723,791	3,017,909	0.127982	56.00
57.00	05700	CT SCAN	6,016,694	11,827,827	17,844,521	0.061226	57.00
58.00	05800	MRI	951,754	2,708,673	3,660,427	0.110986	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,822,501	2,152,344	6,974,845	0.202510	59.00
60.00	06000	LABORATORY	19,486,908	12,977,815	32,464,723	0.124447	60.00
65.00	06500	RESPIRATORY THERAPY	6,293,089	535,601	6,828,690	0.189954	65.00
66.00	06600	PHYSICAL THERAPY	634,212	2,090,899	2,725,111	0.286933	66.00
67.00	06700	OCCUPATIONAL THERAPY	363,672	21,007	384,679	0.328518	67.00
68.00	06800	SPEECH PATHOLOGY	206,793	8,903	215,696	0.189647	68.00
69.00	06900	ELECTROCARDIOLOGY	3,994,564	3,185,314	7,179,878	0.120116	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	147,512	38,020	185,532	0.381589	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,343,805	3,015,379	6,359,184	0.381878	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,821,356	2,541,000	8,362,356	0.311723	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,521,177	6,585,525	22,106,702	0.211049	73.00
74.00	07400	RENAL DIALYSIS	507,870	0	507,870	0.358753	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	11,019	1,932,312	1,943,331	0.348181	90.00
91.00	09100	EMERGENCY	7,537,927	23,872,714	31,410,641	0.185979	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	252,580	2,484,334	2,736,914	0.454565	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	135,297,512	100,320,859	235,618,371		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	135,297,512	100,320,859	235,618,371		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/27/2014 7:21 pm
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
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.237975		50.00
51.00	05100 RECOVERY ROOM	0.201193		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.241973		52.00
53.00	05300 ANESTHESIOLOGY	0.053766		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.145172		54.00
56.00	05600 RADIOISOTOPE	0.127982		56.00
57.00	05700 CT SCAN	0.061226		57.00
58.00	05800 MRI	0.110986		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.202510		59.00
60.00	06000 LABORATORY	0.124447		60.00
65.00	06500 RESPIRATORY THERAPY	0.189954		65.00
66.00	06600 PHYSICAL THERAPY	0.286933		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.328518		67.00
68.00	06800 SPEECH PATHOLOGY	0.189647		68.00
69.00	06900 ELECTROCARDIOLOGY	0.120116		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.381589		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.381878		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.311723		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.211049		73.00
74.00	07400 RENAL DIALYSIS	0.358753		74.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.348181		90.00
91.00	09100 EMERGENCY	0.185979		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.454565		92.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140292

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

Worksheet C
Part I
Date/Time Prepared:
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		Title XIX		Hospital		Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	19,718,865		19,718,865	0	19,718,865	30.00
31.00	03100 INTENSIVE CARE UNIT	4,095,672		4,095,672	0	4,095,672	31.00
40.00	04000 SUBPROVIDER - I/PF	4,244,562		4,244,562	0	4,244,562	40.00
43.00	04300 NURSERY	1,179,147		1,179,147	0	1,179,147	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	3,593,708		3,593,708	0	3,593,708	50.00
51.00	05100 RECOVERY ROOM	548,322		548,322	0	548,322	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,771,879		1,771,879	0	1,771,879	52.00
53.00	05300 ANESTHESIOLOGY	230,287		230,287	0	230,287	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,860,080		1,860,080	0	1,860,080	54.00
56.00	05600 RADIOISOTOPE	386,237		386,237	0	386,237	56.00
57.00	05700 CT SCAN	1,092,553		1,092,553	0	1,092,553	57.00
58.00	05800 MRI	406,257		406,257	0	406,257	58.00
59.00	05900 CARDIAC CATHETERIZATION	1,412,479		1,412,479	0	1,412,479	59.00
60.00	06000 LABORATORY	4,040,131		4,040,131	0	4,040,131	60.00
65.00	06500 RESPIRATORY THERAPY	1,297,137	0	1,297,137	0	1,297,137	65.00
66.00	06600 PHYSICAL THERAPY	781,925	0	781,925	0	781,925	66.00
67.00	06700 OCCUPATIONAL THERAPY	126,374	0	126,374	0	126,374	67.00
68.00	06800 SPEECH PATHOLOGY	40,906	0	40,906	0	40,906	68.00
69.00	06900 ELECTROCARDIOLOGY	862,416		862,416	0	862,416	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	70,797		70,797	0	70,797	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,428,435		2,428,435	0	2,428,435	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2,606,740		2,606,740	0	2,606,740	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,665,596		4,665,596	0	4,665,596	73.00
74.00	07400 RENAL DIALYSIS	182,200		182,200	0	182,200	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	676,631		676,631	0	676,631	90.00
91.00	09100 EMERGENCY	5,841,724		5,841,724	0	5,841,724	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,244,104		1,244,104	0	1,244,104	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	65,405,164	0	65,405,164	0	65,405,164	200.00
201.00	Less Observation Beds	1,244,104		1,244,104		1,244,104	201.00
202.00	Total (see instructions)	64,161,060	0	64,161,060	0	64,161,060	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140292

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

Worksheet C
Part I
Date/Time Prepared:
5/27/2014 7:21 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	30,588,868		30,588,868		30.00
31.00	03100	INTENSIVE CARE UNIT	5,429,336		5,429,336		31.00
40.00	04000	SUBPROVIDER - IPF	7,544,516		7,544,516		40.00
43.00	04300	NURSERY	797,352		797,352		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,050,663	9,050,565	15,101,228	0.237975	50.00
51.00	05100	RECOVERY ROOM	889,765	1,835,592	2,725,357	0.201193	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,276,881	149,784	1,426,665	1.241973	52.00
53.00	05300	ANESTHESIOLOGY	1,780,281	2,502,814	4,283,095	0.053766	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,732,299	9,080,646	12,812,945	0.145172	54.00
56.00	05600	RADIOISOTOPE	1,294,118	1,723,791	3,017,909	0.127982	56.00
57.00	05700	CT SCAN	6,016,694	11,827,827	17,844,521	0.061226	57.00
58.00	05800	MRI	951,754	2,708,673	3,660,427	0.110986	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,822,501	2,152,344	6,974,845	0.202510	59.00
60.00	06000	LABORATORY	19,486,908	12,977,815	32,464,723	0.124447	60.00
65.00	06500	RESPIRATORY THERAPY	6,293,089	535,601	6,828,690	0.189954	65.00
66.00	06600	PHYSICAL THERAPY	634,212	2,090,899	2,725,111	0.286933	66.00
67.00	06700	OCCUPATIONAL THERAPY	363,672	21,007	384,679	0.328518	67.00
68.00	06800	SPEECH PATHOLOGY	206,793	8,903	215,696	0.189647	68.00
69.00	06900	ELECTROCARDIOLOGY	3,994,564	3,185,314	7,179,878	0.120116	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	147,512	38,020	185,532	0.381589	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,343,805	3,015,379	6,359,184	0.381878	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,821,356	2,541,000	8,362,356	0.311723	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,521,177	6,585,525	22,106,702	0.211049	73.00
74.00	07400	RENAL DIALYSIS	507,870	0	507,870	0.358753	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	11,019	1,932,312	1,943,331	0.348181	90.00
91.00	09100	EMERGENCY	7,537,927	23,872,714	31,410,641	0.185979	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	252,580	2,484,334	2,736,914	0.454565	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	135,297,512	100,320,859	235,618,371		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	135,297,512	100,320,859	235,618,371		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/27/2014 7:21 pm
		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
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
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
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part I Date/Time Prepared: 5/27/2014 7:21 pm
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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)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,666,421	0	1,666,421	23,125	72.06	30.00
31.00	INTENSIVE CARE UNIT	240,460	0	240,460	2,476	97.12	31.00
40.00	SUBPROVIDER - IPF	294,539	0	294,539	5,143	57.27	40.00
43.00	NURSERY	160,357		160,357	862	186.03	43.00
200.00	Total (Lines 30-199)	2,361,777		2,361,777	31,606		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	8,881	639,965				
31.00	INTENSIVE CARE UNIT	1,399	135,871				
40.00	SUBPROVIDER - IPF	4,242	242,939				
43.00	NURSERY	0	0				
200.00	Total (Lines 30-199)	14,522	1,018,775				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/27/2014 7:21 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	411,367	15,101,228	0.027241	2,991,851	81,501	50.00
51.00	05100 RECOVERY ROOM	27,708	2,725,357	0.010167	368,695	3,749	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	167,902	1,426,665	0.117688	7,850	924	52.00
53.00	05300 ANESTHESIOLOGY	19,698	4,283,095	0.004599	686,668	3,158	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	114,114	12,812,945	0.008906	2,007,430	17,878	54.00
56.00	05600 RADIOISOTOPE	45,474	3,017,909	0.015068	727,139	10,957	56.00
57.00	05700 CT SCAN	114,971	17,844,521	0.006443	2,642,148	17,023	57.00
58.00	05800 MRI	55,072	3,660,427	0.015045	281,517	4,235	58.00
59.00	05900 CARDIAC CATHETERIZATION	114,983	6,974,845	0.016485	1,586,004	26,145	59.00
60.00	06000 LABORATORY	172,728	32,464,723	0.005320	8,333,414	44,334	60.00
65.00	06500 RESPIRATORY THERAPY	27,664	6,828,690	0.004051	3,451,096	13,980	65.00
66.00	06600 PHYSICAL THERAPY	37,371	2,725,111	0.013714	381,447	5,231	66.00
67.00	06700 OCCUPATIONAL THERAPY	3,918	384,679	0.010185	195,821	1,994	67.00
68.00	06800 SPEECH PATHOLOGY	2,408	215,696	0.011164	138,163	1,542	68.00
69.00	06900 ELECTROCARDIOLOGY	89,482	7,179,878	0.012463	2,001,773	24,948	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	11,506	185,532	0.062016	56,637	3,512	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	78,062	6,359,184	0.012275	1,675,937	20,572	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	73,427	8,362,356	0.008781	2,528,870	22,206	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	84,560	22,106,702	0.003825	6,394,545	24,459	73.00
74.00	07400 RENAL DIALYSIS	539	507,870	0.001061	362,904	385	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	162,328	1,943,331	0.083531	985	82	90.00
91.00	09100 EMERGENCY	812,667	31,410,641	0.025872	2,776,996	71,846	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	105,138	2,736,914	0.038415	181,910	6,988	92.00
200.00	Total (lines 50-199)	2,733,087	191,258,299		39,779,800	407,649	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part III Date/Time Prepared: 5/27/2014 7:21 pm
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Cost Center Description	Title XVIII					Hospital	
	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	PPS		Total Costs (sum of cols. 1 through 3, minus col. 4)
	1.00	2.00	3.00	4.00	5.00		

INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
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
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)	PSA Adj. Nursing School
	6.00	7.00	8.00	9.00	11.00

INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	23,125	0.00	8,881	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,476	0.00	1,399	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	5,143	0.00	4,242	0	0	40.00
43.00	04300	NURSERY	862	0.00	0	0	0	43.00
200.00		Total (lines 30-199)	31,606		14,522	0	0	200.00

Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost
	12.00	13.00

INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0				30.00
31.00	03100	INTENSIVE CARE UNIT	0	0				31.00
40.00	04000	SUBPROVIDER - IPF	0	0				40.00
43.00	04300	NURSERY	0	0				43.00
200.00		Total (lines 30-199)	0	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140292

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

Worksheet D
Part IV
Date/Time Prepared:
5/27/2014 7:21 pm

Cost Center Description		Title XVIII				Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)			
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00	
57.00	05700	CT SCAN	0	0	0	0	0	57.00	
58.00	05800	MRI	0	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00	06000	LABORATORY	0	0	0	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	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	0	0	0	0	0	74.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00	
200.00		Total (lines 50-199)	0	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/27/2014 7:21 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	15,101,228	0.000000	0.000000	2,991,851	50.00
51.00	05100 RECOVERY ROOM	0	2,725,357	0.000000	0.000000	368,695	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1,426,665	0.000000	0.000000	7,850	52.00
53.00	05300 ANESTHESIOLOGY	0	4,283,095	0.000000	0.000000	686,668	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	12,812,945	0.000000	0.000000	2,007,430	54.00
56.00	05600 RADIOISOTOPE	0	3,017,909	0.000000	0.000000	727,139	56.00
57.00	05700 CT SCAN	0	17,844,521	0.000000	0.000000	2,642,148	57.00
58.00	05800 MRI	0	3,660,427	0.000000	0.000000	281,517	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	6,974,845	0.000000	0.000000	1,586,004	59.00
60.00	06000 LABORATORY	0	32,464,723	0.000000	0.000000	8,333,414	60.00
65.00	06500 RESPIRATORY THERAPY	0	6,828,690	0.000000	0.000000	3,451,096	65.00
66.00	06600 PHYSICAL THERAPY	0	2,725,111	0.000000	0.000000	381,447	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	384,679	0.000000	0.000000	195,821	67.00
68.00	06800 SPEECH PATHOLOGY	0	215,696	0.000000	0.000000	138,163	68.00
69.00	06900 ELECTROCARDIOLOGY	0	7,179,878	0.000000	0.000000	2,001,773	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	185,532	0.000000	0.000000	56,637	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,359,184	0.000000	0.000000	1,675,937	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	8,362,356	0.000000	0.000000	2,528,870	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	22,106,702	0.000000	0.000000	6,394,545	73.00
74.00	07400 RENAL DIALYSIS	0	507,870	0.000000	0.000000	362,904	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	1,943,331	0.000000	0.000000	985	90.00
91.00	09100 EMERGENCY	0	31,410,641	0.000000	0.000000	2,776,996	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2,736,914	0.000000	0.000000	181,910	92.00
200.00	Total (lines 50-199)	0	191,258,299			39,779,800	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140292

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

Worksheet D
Part IV
Date/Time Prepared:
5/27/2014 7:21 pm

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
Title XVIII Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	2,574,489	0	0	0 50.00
51.00	05100	RECOVERY ROOM	0	495,890	0	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	250	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0	665,563	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,235,316	0	0	0 54.00
56.00	05600	RADIOISOTOPE	0	618,949	0	0	0 56.00
57.00	05700	CT SCAN	0	2,359,618	0	0	0 57.00
58.00	05800	MRI	0	563,298	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	522,624	0	0	0 59.00
60.00	06000	LABORATORY	0	243,148	0	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	0	493,938	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	405	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	195	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	825,245	0	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	17,793	0	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	818,389	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,102,334	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,370,016	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0 74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	75,562	0	0	0 90.00
91.00	09100	EMERGENCY	0	2,574,246	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	620,667	0	0	0 92.00
200.00		Total (lines 50-199)	0	19,177,935	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/27/2014 7:21 pm
Title XVIII		Hospital	PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
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
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 7:21 pm
		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	0.237975	2,574,489	0	0	612,664 50.00
51.00	05100 RECOVERY ROOM	0.201193	495,890	0	0	99,770 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.241973	250	0	0	310 52.00
53.00	05300 ANESTHESIOLOGY	0.053766	665,563	0	0	35,785 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.145172	1,235,316	0	0	179,333 54.00
56.00	05600 RADIOISOTOPE	0.127982	618,949	0	0	79,214 56.00
57.00	05700 CT SCAN	0.061226	2,359,618	0	0	144,470 57.00
58.00	05800 MRI	0.110986	563,298	0	0	62,518 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.202510	522,624	0	0	105,837 59.00
60.00	06000 LABORATORY	0.124447	243,148	0	0	30,259 60.00
65.00	06500 RESPIRATORY THERAPY	0.189954	493,938	0	0	93,825 65.00
66.00	06600 PHYSICAL THERAPY	0.286933	405	0	0	116 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.328518	195	0	0	64 67.00
68.00	06800 SPEECH PATHOLOGY	0.189647	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.120116	825,245	0	0	99,125 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.381589	17,793	0	0	6,790 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.381878	818,389	0	0	312,525 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.311723	1,102,334	0	0	343,623 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.211049	3,370,016	319	27,498	711,239 73.00
74.00	07400 RENAL DIALYSIS	0.358753	0	0	0	0 74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.348181	75,562	0	0	26,309 90.00
91.00	09100 EMERGENCY	0.185979	2,574,246	0	0	478,756 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.454565	620,667	0	0	282,133 92.00
200.00	Subtotal (see instructions)		19,177,935	319	27,498	3,704,665 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00	Net Charges (line 200 +/- line 201)		19,177,935	319	27,498	3,704,665 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 7:21 pm
		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
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
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
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	67	5,803	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00	Subtotal (see instructions)	67	5,803	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	67	5,803	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140292		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part II Date/Time Prepared: 5/27/2014 7:21 pm	
		Component CCN: 14S292		Title XVIII		Subprovider - IPF	
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	411,367	15,101,228	0.027241	6,376	174
51.00	05100	RECOVERY ROOM	27,708	2,725,357	0.010167	1,218	12
52.00	05200	DELIVERY ROOM & LABOR ROOM	167,902	1,426,665	0.117688	0	0
53.00	05300	ANESTHESIOLOGY	19,698	4,283,095	0.004599	1,662	8
54.00	05400	RADIOLOGY-DIAGNOSTIC	114,114	12,812,945	0.008906	75,293	671
56.00	05600	RADIOISOTOPE	45,474	3,017,909	0.015068	6,157	93
57.00	05700	CT SCAN	114,971	17,844,521	0.006443	60,286	388
58.00	05800	MRI	55,072	3,660,427	0.015045	15,449	232
59.00	05900	CARDIAC CATHETERIZATION	114,983	6,974,845	0.016485	0	0
60.00	06000	LABORATORY	172,728	32,464,723	0.005320	827,465	4,402
65.00	06500	RESPIRATORY THERAPY	27,664	6,828,690	0.004051	306,409	1,241
66.00	06600	PHYSICAL THERAPY	37,371	2,725,111	0.013714	15,125	207
67.00	06700	OCCUPATIONAL THERAPY	3,918	384,679	0.010185	11,999	122
68.00	06800	SPEECH PATHOLOGY	2,408	215,696	0.011164	13,680	153
69.00	06900	ELECTROCARDIOLOGY	89,482	7,179,878	0.012463	72,244	900
70.00	07000	ELECTROENCEPHALOGRAPHY	11,506	185,532	0.062016	846	52
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	78,062	6,359,184	0.012275	13,210	162
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	73,427	8,362,356	0.008781	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	84,560	22,106,702	0.003825	1,133,040	4,334
74.00	07400	RENAL DIALYSIS	539	507,870	0.001061	9,172	10
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	162,328	1,943,331	0.083531	0	0
91.00	09100	EMERGENCY	812,667	31,410,641	0.025872	39,739	1,028
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,736,914	0.000000	0	0
200.00		Total (lines 50-199)	2,627,949	191,258,299		2,609,370	14,189

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140292 Component CCN: 14S292	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/27/2014 7:21 pm
	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	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	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	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140292 Component CCN: 14S292	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/27/2014 7:21 pm
	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	15,101,228	0.000000	0.000000	6,376	50.00
51.00	05100	RECOVERY ROOM	0	2,725,357	0.000000	0.000000	1,218	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,426,665	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	4,283,095	0.000000	0.000000	1,662	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,812,945	0.000000	0.000000	75,293	54.00
56.00	05600	RADIOISOTOPE	0	3,017,909	0.000000	0.000000	6,157	56.00
57.00	05700	CT SCAN	0	17,844,521	0.000000	0.000000	60,286	57.00
58.00	05800	MRI	0	3,660,427	0.000000	0.000000	15,449	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	6,974,845	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	32,464,723	0.000000	0.000000	827,465	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,828,690	0.000000	0.000000	306,409	65.00
66.00	06600	PHYSICAL THERAPY	0	2,725,111	0.000000	0.000000	15,125	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	384,679	0.000000	0.000000	11,999	67.00
68.00	06800	SPEECH PATHOLOGY	0	215,696	0.000000	0.000000	13,680	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,179,878	0.000000	0.000000	72,244	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	185,532	0.000000	0.000000	846	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,359,184	0.000000	0.000000	13,210	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,362,356	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	22,106,702	0.000000	0.000000	1,133,040	73.00
74.00	07400	RENAL DIALYSIS	0	507,870	0.000000	0.000000	9,172	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,943,331	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	31,410,641	0.000000	0.000000	39,739	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,736,914	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	191,258,299			2,609,370	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140292 Component CCN: 14S292	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/27/2014 7:21 pm
	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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	2,925	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	1,911	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2,449	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	7,285	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140292 Component CCN: 14S292	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/27/2014 7:21 pm
	Title XVII	Subprovider - IPF	PPS

Cost Center Description		PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
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
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140292 Component CCN: 14S292	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 7:21 pm
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			PPS Services (see inst.)	PPS Services (see inst.)		
		Cost Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.237975	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.201193	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.241973	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.053766	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.145172	2,925	0	0	425	54.00
56.00	05600	RADIOISOTOPE	0.127982	0	0	0	0	56.00
57.00	05700	CT SCAN	0.061226	0	0	0	0	57.00
58.00	05800	MRI	0.110986	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.202510	0	0	0	0	59.00
60.00	06000	LABORATORY	0.124447	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.189954	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.286933	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.328518	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.189647	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.120116	1,911	0	0	230	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.381589	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.381878	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.311723	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211049	2,449	0	0	517	73.00
74.00	07400	RENAL DIALYSIS	0.358753	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.348181	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.185979	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.454565	0	0	0	0	92.00
200.00		Subtotal (see instructions)		7,285	0	0	1,172	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		7,285	0	0	1,172	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 7:21 pm
	Component CCN: 14S292	Title XVII I	Subprovider - IPF

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
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00 05600 RADIOISOTOPE	0	0	56.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MRI	0	0	58.00
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
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00 Subtotal (see instructions)	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 140292 Component CCN: 14S292	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/27/2014 7:21 pm
	Title XIX	Subprovider - IPF	Tefra

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	411,367	15,101,228	0.027241	0	0	50.00
51.00	05100 RECOVERY ROOM	27,708	2,725,357	0.010167	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	167,902	1,426,665	0.117688	0	0	52.00
53.00	05300 ANESTHESIOLOGY	19,698	4,283,095	0.004599	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	114,114	12,812,945	0.008906	0	0	54.00
56.00	05600 RADIOISOTOPE	45,474	3,017,909	0.015068	0	0	56.00
57.00	05700 CT SCAN	114,971	17,844,521	0.006443	0	0	57.00
58.00	05800 MRI	55,072	3,660,427	0.015045	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	114,983	6,974,845	0.016485	0	0	59.00
60.00	06000 LABORATORY	172,728	32,464,723	0.005320	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	27,664	6,828,690	0.004051	0	0	65.00
66.00	06600 PHYSICAL THERAPY	37,371	2,725,111	0.013714	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	3,918	384,679	0.010185	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	2,408	215,696	0.011164	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	89,482	7,179,878	0.012463	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	11,506	185,532	0.062016	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	78,062	6,359,184	0.012275	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	73,427	8,362,356	0.008781	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	84,560	22,106,702	0.003825	0	0	73.00
74.00	07400 RENAL DIALYSIS	539	507,870	0.001061	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	162,328	1,943,331	0.083531	0	0	90.00
91.00	09100 EMERGENCY	812,667	31,410,641	0.025872	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2,736,914	0.000000	0	0	92.00
200.00	Total (lines 50-199)	2,627,949	191,258,299		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140292 Component CCN: 14S292	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/27/2014 7:21 pm
	Title XIX	Subprovider - IPF	Tefra

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	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	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	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140292 Component CCN: 14S292	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/27/2014 7:21 pm
	Title XIX	Subprovider - IPF	Tefra

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient Program Charges
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 + col. 7)	Ratio of Cost to Charges (col. 6 ÷ col. 7)	
	6.00	7.00	8.00	9.00	10.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	15,101,228	0.000000	0.000000	0 50.00
51.00 05100 RECOVERY ROOM	0	2,725,357	0.000000	0.000000	0 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	1,426,665	0.000000	0.000000	0 52.00
53.00 05300 ANESTHESIOLOGY	0	4,283,095	0.000000	0.000000	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	12,812,945	0.000000	0.000000	0 54.00
56.00 05600 RADIOISOTOPE	0	3,017,909	0.000000	0.000000	0 56.00
57.00 05700 CT SCAN	0	17,844,521	0.000000	0.000000	0 57.00
58.00 05800 MRI	0	3,660,427	0.000000	0.000000	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0	6,974,845	0.000000	0.000000	0 59.00
60.00 06000 LABORATORY	0	32,464,723	0.000000	0.000000	0 60.00
65.00 06500 RESPIRATORY THERAPY	0	6,828,690	0.000000	0.000000	0 65.00
66.00 06600 PHYSICAL THERAPY	0	2,725,111	0.000000	0.000000	0 66.00
67.00 06700 OCCUPATIONAL THERAPY	0	384,679	0.000000	0.000000	0 67.00
68.00 06800 SPEECH PATHOLOGY	0	215,696	0.000000	0.000000	0 68.00
69.00 06900 ELECTROCARDIOLOGY	0	7,179,878	0.000000	0.000000	0 69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	185,532	0.000000	0.000000	0 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,359,184	0.000000	0.000000	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	8,362,356	0.000000	0.000000	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	22,106,702	0.000000	0.000000	0 73.00
74.00 07400 RENAL DIALYSIS	0	507,870	0.000000	0.000000	0 74.00
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0	1,943,331	0.000000	0.000000	0 90.00
91.00 09100 EMERGENCY	0	31,410,641	0.000000	0.000000	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2,736,914	0.000000	0.000000	0 92.00
200.00 Total (lines 50-199)	0	191,258,299			0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140292 Component CCN: 14S292	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/27/2014 7:21 pm
	Title XIX	Subprovider - IPF	Tefra

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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	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	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140292 Component CCN: 14S292	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/27/2014 7:21 pm
	Title XIX	Subprovider - IPF	Tefra

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
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
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00	Total (lines 50-199)	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/27/2014 7:21 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		23,125	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		23,125	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)		21,666	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)		8,881	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)		19,718,865	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)		19,718,865	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)		19,718,865	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)		852.71	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		7,572,918	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)		7,572,918	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/27/2014 7:21 pm		
Cost Center Description			Title XVIII		Hospital	PPS	
	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	4,095,672	2,476	1,654.15	1,399	2,314,156	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)					7,393,729	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					17,280,803	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)					775,836	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					407,649	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,183,485	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					16,097,318	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)					1,459	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					852.71	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,244,104	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140292		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/27/2014 7:21 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,666,421	19,718,865	0.084509	1,244,104	105,138	90.00
91.00	Nursing School cost	0	19,718,865	0.000000	1,244,104	0	91.00
92.00	Allied health cost	0	19,718,865	0.000000	1,244,104	0	92.00
93.00	All other Medical Education	0	19,718,865	0.000000	1,244,104	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Component CCN: 14S292		Date/Time Prepared: 5/27/2014 7:21 pm
		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)		5,143	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,143	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,143	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		4,242	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,244,562	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,244,562	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,244,562	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)		825.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,500,965	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,500,965	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140292		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
		Component CCN: 14S292				Date/Time Prepared: 5/27/2014 7:21 pm	
		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		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)					454,885		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,955,850		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)					242,939		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					14,189		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					257,128		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					3,698,722		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: 140292 Component CCN: 14S292		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/27/2014 7:21 pm	
		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	294,539	4,244,562	0.069392	0	0	90.00
91.00	Nursing School cost	0	4,244,562	0.000000	0	0	91.00
92.00	Allied health cost	0	4,244,562	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,244,562	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Component CCN: 14S292		Date/Time Prepared: 5/27/2014 7:21 pm
		Title XIX	Subprovider - IPF	Tefra
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)		5,143	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,143	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,143	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)		247	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)		862	15.00
16.00	Nursery days (title V or XIX only)		699	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,244,562	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,244,562	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,244,562	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)		825.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		203,852	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)		203,852	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140292		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
		Component CCN: 14S292		Date/Time Prepared: 5/27/2014 7:21 pm			
		Title XIX		Subprovider - IPF		Tefra	
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)					0	0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					203,852	0	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	0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	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)					203,852	0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						17	54.00
55.00 Target amount per discharge					0.00	0	55.00
56.00 Target amount (line 54 x line 55)					0	0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					-203,852	0	57.00
58.00 Bonus payment (see instructions)					0	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	0	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	0	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	0	61.00
62.00 Relief payment (see instructions)					0	0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	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	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	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	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	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	0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	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	0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	0	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140292 Component CCN: 14S292		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/27/2014 7:21 pm	
		Title XIX		Subprovider - IPF		Tefra	
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	4,244,562	0.000000	0	0	90.00
91.00	Nursing School cost	0	4,244,562	0.000000	0	0	91.00
92.00	Allied health cost	0	4,244,562	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,244,562	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/27/2014 7:21 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		11,847,209	30.00
31.00	03100	INTENSIVE CARE UNIT		3,189,582	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.237975	2,991,851	50.00
51.00	05100	RECOVERY ROOM	0.201193	368,695	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.241973	7,850	52.00
53.00	05300	ANESTHESIOLOGY	0.053766	686,668	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.145172	2,007,430	54.00
56.00	05600	RADIOISOTOPE	0.127982	727,139	56.00
57.00	05700	CT SCAN	0.061226	2,642,148	57.00
58.00	05800	MRI	0.110986	281,517	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.202510	1,586,004	59.00
60.00	06000	LABORATORY	0.124447	8,333,414	60.00
65.00	06500	RESPIRATORY THERAPY	0.189954	3,451,096	65.00
66.00	06600	PHYSICAL THERAPY	0.286933	381,447	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.328518	195,821	67.00
68.00	06800	SPEECH PATHOLOGY	0.189647	138,163	68.00
69.00	06900	ELECTROCARDIOLOGY	0.120116	2,001,773	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.381589	56,637	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.381878	1,675,937	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.311723	2,528,870	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211049	6,394,545	73.00
74.00	07400	RENAL DIALYSIS	0.358753	362,904	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.348181	985	90.00
91.00	09100	EMERGENCY	0.185979	2,776,996	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.454565	181,910	92.00
200.00		Total (sum of lines 50-94 and 96-98)		39,779,800	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)		39,779,800	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3	
		Component CCN: 14S292		Date/Time Prepared: 5/27/2014 7:21 pm	
		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		6,205,884		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.237975	6,376	1,517	50.00
51.00	05100 RECOVERY ROOM	0.201193	1,218	245	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.241973	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.053766	1,662	89	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.145172	75,293	10,930	54.00
56.00	05600 RADIOISOTOPE	0.127982	6,157	788	56.00
57.00	05700 CT SCAN	0.061226	60,286	3,691	57.00
58.00	05800 MRI	0.110986	15,449	1,715	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.202510	0	0	59.00
60.00	06000 LABORATORY	0.124447	827,465	102,976	60.00
65.00	06500 RESPIRATORY THERAPY	0.189954	306,409	58,204	65.00
66.00	06600 PHYSICAL THERAPY	0.286933	15,125	4,340	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.328518	11,999	3,942	67.00
68.00	06800 SPEECH PATHOLOGY	0.189647	13,680	2,594	68.00
69.00	06900 ELECTROCARDIOLOGY	0.120116	72,244	8,678	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.381589	846	323	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.381878	13,210	5,045	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.311723	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.211049	1,133,040	239,127	73.00
74.00	07400 RENAL DIALYSIS	0.358753	9,172	3,290	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.348181	0	0	90.00
91.00	09100 EMERGENCY	0.185979	39,739	7,391	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.454565	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		2,609,370	454,885	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)		2,609,370		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/27/2014 7:21 pm
		Title XVII	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)		9,526,603	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		2,661,659	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)		271,809	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		417,439	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		119.81	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)		8.18	30.00
31.00	Percentage of Medicaid patient days (see instructions)		35.77	31.00
32.00	Sum of lines 30 and 31		43.95	32.00
33.00	Allowable disproportionate share percentage (see instructions)		25.47	33.00
34.00	Disproportionate share adjustment (see instructions)		2,595,907	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/27/2014 7:21 pm	
		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)			0.000300661	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			2,719,893	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			685,563	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		685,563		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)		15,741,541		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)			0	48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		15,741,541		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		1,092,374		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			0	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)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		16,833,915		59.00
60.00	Primary payer payments			3,816	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		16,830,099		61.00
62.00	Deductibles billed to program beneficiaries			1,132,500	62.00
63.00	Coinurance billed to program beneficiaries			191,794	63.00
64.00	Allowable bad debts (see instructions)			567,019	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			368,562	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			524,775	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		15,874,367		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			-4,110	70.00
70.92	Bundled Model 1 discount amount			0	70.92
70.93	HVBP incentive payment (see instructions)			-11,021	70.93
70.94	Hospital readmissions reduction adjustment (see instructions)			-34,257	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: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/27/2014 7:21 pm	
		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)		15,824,979		71.00
71.01	Sequestration adjustment (see instructions)		238,957		71.01
72.00	Interim payments		15,405,358		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		180,664		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		800,706		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 DSH PAYMENT PERCENTAGE		Provider CCN: 140292		Period: From 01/01/2013 To 12/31/2013		Worksheet DSH	
		Title XVIII		Hospital		Date/Time Prepared: 5/27/2014 7:21 pm	
		PPS					
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	8.18	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	35.77	0.00			35.77	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	43.95	0.00			35.77	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	119.81	0.00			119.81	5.00
6.00	Disproportionate Share Payment Percentage (transfer to Worksheet E, Part A, line 33)	25.47	0.00			18.73	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes				No	9.00
10.00	S-2, Line 45	Yes				Yes	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	8.18	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	5,418	0			5,418	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	1,127	0			1,127	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	35	0			35	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	2,393	0			2,393	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	8,973	0			8,973	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	25,004	0			25,004	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	84	0			84	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	25,088	0			25,088	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	35.77	0.00			35.77	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140292		Period: From 01/01/2013 To 12/31/2013		Worksheet DSH Date/Time Prepared: 5/27/2014 7:21 pm	
		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	25.47		0.00	True	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False	29.00
30.00	Line 28 or 29 as applicable		25.47		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		25.47		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE							
32.00	Does the hospital qualify under the Pickle amendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet DSH Date/Time Prepared: 5/27/2014 7:21 pm
		Title XVIII	Hospital	PPS

		Revised		
		Percentage		
		6.00		
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE				
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	18.73		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00		29.00
30.00	Line 28 or 29 as applicable	18.73		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	18.73		31.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 140292

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/27/2014 7:21 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013	1.01	9,526,603	0	9,526,603	0	9,526,603	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013	1.02	2,661,659	0	0	2,661,659	2,661,659	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI	1.03	0	0	0	0	0	1.03
2.00	Outlier payments for discharges (see instructions)	2.00	271,809	0	235,046	36,763	271,809	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	417,439	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	Amount from Worksheet E Part A, line 27 (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2547	0.2547	0.2547	0.2547		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	2,595,907	0	2,426,426	169,481	2,595,907	11.00
11.01	Uncompensated care payments	36.00	685,563	0	0	685,563	685,563	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	15,741,541	0	12,188,075	3,553,466	15,741,541	13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49.00	15,741,541	0	12,188,075	3,553,466	15,741,541	15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50.00	1,092,374	0	855,214	237,160	1,092,374	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	13,043,289	3,790,626	16,833,915	19.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 140292

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/27/2014 7:21 pm

		Title XVIII		Hospital		PPS		
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	970,296	0	757,596	212,701	970,297	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	31,743	0	27,086	4,657	31,743	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (line 20 times line 22)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0931	0.0931	0.0931	0.0931		24.00
25.00	Disproportionate share adjustment (line 20 times line 24)	11.00	90,335	0	70,533	19,802	90,335	25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	12.00	1,092,374	0	855,214	237,160	1,092,374	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to W/S E Part A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/27/2014 7:21 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,870	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		3,704,665	2.00
3.00	PPS payments		3,104,778	3.00
4.00	Outlier payment (see instructions)		31,461	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		5,870	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		27,817	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)		27,817	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)		27,817	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		21,947	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		5,870	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)		3,136,239	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		64	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		690,046	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		2,451,999	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,451,999	30.00
31.00	Primary payer payments		508	31.00
32.00	Subtotal (line 30 minus line 31)		2,451,491	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)		243,806	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		158,474	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		231,523	36.00
37.00	Subtotal (see instructions)		2,609,965	37.00
38.00	MSP-LCC reconciliation amount from PS&R		1	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)		2,609,964	40.00
40.01	Sequestration adjustment (see instructions)		39,410	40.01
41.00	Interim payments		2,559,417	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		11,137	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
			Overrides	
			1.00	
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0
				112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/27/2014 7:21 pm
		Component CCN: 14S292	Title XVII I	Subprovider - IPF
		PPS		
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,172	2.00
3.00	PPS payments		529	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		529	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)		124	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)		405	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)		405	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		405	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)		405	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)		405	40.00
40.01	Sequestration adjustment (see instructions)		6	40.01
41.00	Interim payments		397	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		2	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
		Overrides		
		1.00		
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)		0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140292

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

Worksheet E-1
Part I
Date/Time Prepared:
5/27/2014 7:21 pm

		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		15,418,964		2,542,423	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0	11/18/2013	16,994	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	11/18/2013	13,606		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)		-13,606		16,994	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)		15,405,358		2,559,417	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		180,664		11,137	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		15,586,022		2,570,554	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: 140292
Component CCN: 14S292

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

Worksheet E-1
Part I
Date/Time Prepared:
5/27/2014 7:21 pm

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		3,451,245		397	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)		0		0	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)		3,451,245		397	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		24,659		2	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,475,904		399	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: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet E-1 Part II Date/Time Prepared: 5/27/2014 7:21 pm
		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		4,928	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12		10,280	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2		217	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12		24,142	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200		235,618,371	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20		12,436,221	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)		632,456	8.00
9.00	Sequestration adjustment amount (see instructions)		12,649	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		619,807	10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)		591,915	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)		27,892	32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			0108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part II Date/Time Prepared: 5/27/2014 7:21 pm
		Component CCN: 14S292	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)		3,687,839	1.00
2.00	Net IPF PPS Outlier Payments		31,244	2.00
3.00	Net IPF PPS ECT Payments		0	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)		14.090411	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)		3,719,083	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)		3,719,083	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		3,719,083	18.00
19.00	Deductibles		151,308	19.00
20.00	Subtotal (line 18 minus line 19)		3,567,775	20.00
21.00	Coinsurance		64,528	21.00
22.00	Subtotal (line 20 minus line 21)		3,503,247	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		40,582	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		26,378	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		36,605	25.00
26.00	Subtotal (sum of lines 22 and 24)		3,529,625	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)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENT		-430	30.00
30.99	Recovery of Accelerated Depreciation		0	30.99
31.00	Total amount payable to the provider (see instructions)		3,529,195	31.00
31.01	Sequestration adjustment (see instructions)		53,291	31.01
32.00	Interim payments		3,451,245	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		24,659	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		31,244	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

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

Provider CCN: 140292

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

Worksheet G

Date/Time Prepared:
5/27/2014 7:21 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	14,483,778	0	0	0	1.00
2.00	Temporary investments	4,015,436	0	0	0	2.00
3.00	Notes receivable	14,638,476	0	0	0	3.00
4.00	Accounts receivable	-2,875,675	0	0	0	4.00
5.00	Other receivable	1,770,591	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	1,006,201	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	33,038,807	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,869,112	0	0	0	12.00
13.00	Land improvements	78,294	0	0	0	13.00
14.00	Accumulated depreciation	-75,742	0	0	0	14.00
15.00	Buildings	25,052,854	0	0	0	15.00
16.00	Accumulated depreciation	-12,076,582	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	7,215,982	0	0	0	19.00
20.00	Accumulated depreciation	-6,678,437	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	11,951,203	0	0	0	23.00
24.00	Accumulated depreciation	-7,906,566	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	19,430,118	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,816,651	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	4,818,184	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,634,835	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	59,103,760	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	4,350,530	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,597,263	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	681,004	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	9,299,654	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	17,928,451	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	11,424,603	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	19,244	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	11,443,847	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	29,372,298	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	29,731,462				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)	29,731,462	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	59,103,760	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140292

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

Worksheet G-1

Date/Time Prepared:
5/27/2014 7:21 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		19,897,045		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-1,674,929			2.00
3.00	Total (sum of line 1 and line 2)		18,222,116		0	3.00
4.00	DONOR RESTRICTED	578,635		0		4.00
5.00	ADJUSTMENT	10,930,706		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)		11,509,341		0	10.00
11.00	Subtotal (line 3 plus line 10)		29,731,457		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)		29,731,457		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	DONOR RESTRICTED		0			4.00
5.00	ADJUSTMENT		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: 140292

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/27/2014 7:21 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	30,633,868		30,633,868	1.00
2.00	SUBPROVIDER - IPF	7,544,516		7,544,516	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	38,178,384		38,178,384	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,442,466		5,442,466	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)	5,442,466		5,442,466	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	43,620,850		43,620,850	17.00
18.00	Ancillary services	83,140,733	77,882,614	161,023,347	18.00
19.00	Outpatient services	7,537,927	23,872,714	31,410,641	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				26.00
27.00	PROFESSIONAL FEES	0	264,141	264,141	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	134,299,510	102,019,469	236,318,979	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		87,036,319		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		87,036,319		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140292

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

Worksheet G-3

Date/Time Prepared:
5/27/2014 7:21 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	236,318,979	1.00
2.00	Less contractual allowances and discounts on patients' accounts	159,546,044	2.00
3.00	Net patient revenues (line 1 minus line 2)	76,772,935	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	87,036,319	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-10,263,384	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER	8,588,455	24.00
25.00	Total other income (sum of lines 6-24)	8,588,455	25.00
26.00	Total (line 5 plus line 25)	-1,674,929	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,674,929	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140292	Period: From 01/01/2013 To 12/31/2013	Worksheet L Parts I-III Date/Time Prepared: 5/27/2014 7:21 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		970,296	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		31,743	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)		66.14	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)		8.18	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		35.77	8.00
9.00	Sum of lines 7 and 8		43.95	9.00
10.00	Allowable disproportionate share percentage (see instructions)		9.31	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		90,335	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		1,092,374	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