

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: 264012
 Period: From 01/01/2013 To 12/31/2013
 Worksheet 5
 Parts I-III
 Date/Time Prepared: 5/29/2014 3:14 pm

PART I - COST REPORT STATUS

Provider use only
 1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.
 Date: 5/28/2014 Time: 1:28 pm

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CENTERPOINTE HOSPITAL (264012) 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) *J. Malach*
 Officer or Administrator of Provider(s)
 Title CEO
 Date 5/30/2014

Cost Center Description	Title V 1.00	Title XVIII		Title XIX 5.00	Total
		Part A 2.00	Part B 3.00		
PART III - SETTLEMENT SUMMARY					
1.00 Hospital	0	138,493	49,177	0	1,167,200
2.00 Subprovider - IPF	0	0	0	0	0
3.00 Subprovider - IRF	0	0	0	0	0
5.00 Swing bed - SNF	0	0	0	0	0
6.00 Swing bed - NF	0	0	0	0	0
200.00 Total	0	138,493	49,177	0	1,167,200

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.

MEDICARE

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 264012	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/29/2014 3:14 pm
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1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: MO		4.00 Zip Code: 63304		County: ST CHARLES		1.00
1.00	Street: 4801 WELDON SPRINGS PARKWAY	2.00		3.00		4.00		5.00		2.00
2.00	City: ST. CHARLES	3.00		4.00		5.00		6.00		7.00

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
						V	XVIII	XIX		
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00			
3.00	Hospital	CENTERPOINTE HOSPITAL	264012	41180	4	12/31/1980	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									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: 1.00	To: 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)	4		21.00

Inpatient PPS Information		From: 1.00	To: 2.00	
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)			22.01
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
	1.00	2.00	3.00	4.00	5.00	6.00		
24.00	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.	3,697	0	1,832	0	1,882	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0		25.00

	Urban/Rural S	Date of Geogr	
	1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 264012	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/29/2014 3:14 pm
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		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			39.00
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		V	XVIII	XIX	
		1.00	2.00	3.00	

Prospective Payment System (PPS)-Capital					
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00

Teaching Hospitals					
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable.				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.				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	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		Program Name	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.	N		0.00	0.00	61.10

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	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00	2.00	3.00	4.00	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.	N	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
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--this base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000 64.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
			1.00	2.00	3.00
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	N	0.00	0.00	0.000000 65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))
			1.00	2.00	3.00
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010					
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000 66.00

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	N	0.00	0.00	0.000000	67.00

			1.00	2.00	3.00	
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Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.		Y			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)		N	N	0	71.00

Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.		N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	76.00

					1.00	
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Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(i)? Enter "Y" for yes and "N" for no.					86.00

			V		XIX	
			1.00		2.00	

Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00		97.00

Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106.00

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		V	XIX	
		1.00	2.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	38,400	0	0	118.01

		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N	118.02	
119.00	DO NOT USE THIS LINE			119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N		121.00

		1.00	2.00	
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N	125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00

		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)		N	140.00

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1.00		2.00		3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00
142.00	Street:	PO Box:				142.00
143.00	City:	State:		Zip Code:		143.00

		1.00		
144.00	Are provider based physicians' costs included in worksheet A?	Y		144.00
145.00	If costs for renal services are claimed on worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N		145.00

		1.00		2.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N				147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N				149.00

		Part A		Part B		Title V		Title XIX		
		1.00		2.00		3.00		4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital	N		N		N		N		155.00
156.00	Subprovider - IPF	N		N		N		N		156.00
157.00	Subprovider - IRF	N		N		N		N		157.00
158.00	SUBPROVIDER									158.00
159.00	SNF	N		N		N		N		159.00
160.00	HOME HEALTH AGENCY	N		N		N		N		160.00
161.00	CMHC			N		N		N		161.00

		1.00		
Multicampus				
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N		165.00

		Name		County		State		Zip Code		CBSA		FTE/Campus	
		0		1.00		2.00		3.00		4.00		5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5											0.00	

		1.00		
Health Information Technology (HIT) Incentive in the American Recovery and Reinvestment Act				
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	N		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)			0168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.00169.00

		Beginning		Ending		
		1.00		2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 264012	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/29/2014 3:14 pm
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		Y/N	Date	
		1.00	2.00	

General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.

COMPLETED BY ALL HOSPITALS

Provider Organization and Operation

1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
------	--	---	--	--	------

		Y/N	Date	V/I	
		1.00	2.00	3.00	

2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
------	---	---	--	--	------

3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
------	--	---	--	--	------

		Y/N	Type	Date	
		1.00	2.00	3.00	

Financial Data and Reports

4.00	Column 1: were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	04/30/2014	4.00
------	--	---	---	------------	------

5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
------	--	---	--	--	------

		Y/N	Legal Oper.		
		1.00	2.00		

Approved Educational Activities

6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
------	---	---	--	--	------

7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
------	--	---	--	--	------

8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
------	---	---	--	--	------

9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
------	--	---	--	--	------

10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
-------	--	---	--	--	-------

11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on worksheet A? If yes, see instructions.	N			11.00
-------	---	---	--	--	-------

		Y/N			
		1.00			

Bad Debts

12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
-------	--	--	--	---	-------

13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
-------	---	--	--	---	-------

14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
-------	--	--	--	---	-------

Bed Complement

15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
-------	---	--	--	---	-------

		Part A		Part B	
	Description	Y/N	Date	Y/N	
	0	1.00	2.00	3.00	

16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/08/2014	Y	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)	N		N	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
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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
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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.	N		N		21.00
					1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)						
Capital Related Cost						
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N		27.00
Interest Expense						
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N		31.00
Purchased Services						
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N		33.00
Provider-Based Physicians						
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			N		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N		35.00
			Y/N		Date	
			1.00		2.00	
Home Office Costs						
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
					1.00	2.00
Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RONALD		MOORE		41.00
42.00	Enter the employer/company name of the cost report preparer.	CENTERPOINTE HOSPITAL				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	636-441-7300		RMOORE@CPHMO.NER		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)	05/08/2014	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
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.	MEDICARE SPECIALIST	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: 264012

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

Worksheet S-2
Part V
Date/Time Prepared:
5/29/2014 3:14 pm

		1.00	
Cost Report Preparer Contact Information			
1.00	First Name	RONALD	1.00
2.00	Last Name	MOORE	2.00
3.00	Title	MEDICARE SPECIALIST	3.00
4.00	Employer	CENTERPOINTE HOSPITAL	4.00
5.00	Phone Number	(636)441-7300	5.00
6.00	E-mail Address	RMOORE@CPHMO.NET	6.00
7.00	Department	BUSINESS OFFICE	7.00
8.00	Mailing Address 1	4801 WELDON SPRINGS PARKWAY	8.00
9.00	Mailing Address 2		9.00
10.00	City	ST CHARLES	10.00
11.00	State	MO	11.00
12.00	Zip	63304	12.00
Officer or Administrator of Provider Contact Information			
13.00	First Name	TARIQ	13.00
14.00	Last Name	MALIK	14.00
15.00	Title	CHIEF FINANCIAL OFFICER	15.00
16.00	Employer	CENTERPOINTE HOSPITAL	16.00
17.00	Phone Number	(636)441-7300	17.00
18.00	E-mail Address		18.00
19.00	Department	BUSINESS OFFICE	19.00
20.00	Mailing Address 1	4801 WELDON SPRINGS PARKWAY	20.00
21.00	Mailing Address 2		21.00
22.00	City	ST CHARLES	22.00
23.00	State	MO	23.00
24.00	Zip	63304	24.00

		Title V	Title XIX	
		1.00	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	Outpatient	
		1.00	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	Title XIX	
		1.00	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 "o") 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

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P 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	104	37,960	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)		104	37,960	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
8.01 CHEMICAL DEPENDENCY/SAFE	31.01	44	16,060	0.00	0	8.01
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)		148	54,020	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		148				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	8,550	3,697	29,253			1.00
2.00 HMO and other (see instructions)	0	0				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	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	8,550	3,697	29,253			7.00
8.00 INTENSIVE CARE UNIT	0	0	0			8.00
8.01 CHEMICAL DEPENDENCY/SAFE	0	0	6,185			8.01
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)	8,550	3,697	35,438	0.00	325.50	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	325.50	27.00
28.00 Observation Bed Days		0	0			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

Component	Full Time equivalents	Discharges				Total All Patients	
		Nonpaid workers	Title V	Title XVIII	Title XIX		
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	713	352	4,037	1.00
2.00 HMO and other (see instructions)				0			2.00
3.00 HMO IPF Subprovider							3.00
4.00 HMO IRF Subprovider							4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
8.01 CHEMICAL DEPENDENCY/SAFE							8.01
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	713	352		4,037	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 264012

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

Worksheet A

Date/Time Prepared:
5/29/2014 3:14 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification	Reclassified	
		1.00	2.00	3.00	4.00	5.00	
					Reclassifications (See A-6)	Trial Balance (col. 3 + col. 4)	
GENERAL SERVICE COST CENTERS							
1.00	00100		109,082	109,082	2,252,751	2,361,833	1.00
2.00	00200		580,368	580,368	459,205	1,039,573	2.00
3.00	00300		332,851	332,851	-332,851	0	3.00
4.00	00400	152,775	4,858,679	5,011,454	-589	5,010,865	4.00
5.00	00500	4,389,710	6,567,939	10,957,649	-1,574,453	9,383,196	5.00
6.00	00600	236,349	590,408	826,757	-14,685	812,072	6.00
8.00	00800	0	99,907	99,907	0	99,907	8.00
9.00	00900	0	417,093	417,093	0	417,093	9.00
10.00	01000	312,357	884,212	1,196,569	0	1,196,569	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	761,645	20,502	782,147	9,771	791,918	13.00
15.00	01500	46,287	816,109	862,396	0	862,396	15.00
16.00	01600	392,547	207,022	599,569	-16,696	582,873	16.00
17.00	01700	543,241	6,828	550,069	-208	549,861	17.00
18.00	01850	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	6,646,126	1,702,080	8,348,206	154,212	8,502,418	30.00
31.00	03100	0	0	0	0	0	31.00
31.01	03101	1,342,801	475,313	1,818,114	21,599	1,839,713	31.01
ANCILLARY SERVICE COST CENTERS							
70.00	07000	146,253	265,828	412,081	0	412,081	70.00
73.00	07300	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	3,620,725	3,820,100	7,440,825	-996,784	6,444,041	90.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		49,909	49,909	-49,909	0	113.00
118.00		18,590,816	21,804,230	40,395,046	-88,637	40,306,409	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	0	0	0	88,925	88,925	190.01
190.02	19002	228,447	1,197,401	1,425,848	-288	1,425,560	190.02
200.00		18,819,263	23,001,631	41,820,894	0	41,820,894	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 264012

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

Worksheet A

Date/Time Prepared:
5/29/2014 3:14 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	0	2,361,833	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	1,039,573	2.00
3.00	00300 OTHER CAP REL COSTS	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	5,010,865	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-2,239,894	7,143,302	5.00
6.00	00600 MAINTENANCE & REPAIRS	-258	811,814	6.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	99,907	8.00
9.00	00900 HOUSEKEEPING	0	417,093	9.00
10.00	01000 DIETARY	0	1,196,569	10.00
11.00	01100 CAFETERIA	-81,608	-81,608	11.00
13.00	01300 NURSING ADMINISTRATION	0	791,918	13.00
15.00	01500 PHARMACY	0	862,396	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-845	582,028	16.00
17.00	01700 SOCIAL SERVICE	0	549,861	17.00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-866,979	7,635,439	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	31.00
31.01	03101 CHEMICAL DEPENDENCY/SAFE	-241,150	1,598,563	31.01
ANCILLARY SERVICE COST CENTERS				
70.00	07000 ELECTROENCEPHALOGRAPHY	0	412,081	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	-889,355	5,554,686	90.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-4,320,089	35,986,320	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001 COMMUNITY RELATIONS	0	88,925	190.01
190.02	19002 RETAIL PHARMACY	0	1,425,560	190.02
200.00	TOTAL (SUM OF LINES 118-199)	-4,320,089	37,500,805	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 264012

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

Worksheet Non-CMS W
Date/Time Prepared:
5/29/2014 3:14 pm

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
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
6.00	MAINTENANCE & REPAIRS	00600		6.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
18.00	OTHER GENERAL SERVICE (SPECIFY)	01850		18.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
31.01	CHEMICAL DEPENDENCY/SAFE	03101		31.01
ANCILLARY SERVICE COST CENTERS				
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	09000		90.00
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
190.01	COMMUNITY RELATIONS	19001		190.01
190.02	RETAIL PHARMACY	19002		190.02
200.00	TOTAL (SUM OF LINES 118-199)			200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - RECLASS LAB COSTS					
1.00	CHEMICAL DEPENDENCY/SAFE	31.01	0	16,463	1.00
	TOTALS		0	16,463	
B - RECLASS COMMUNITY RELATIONS					
1.00	COMMUNITY RELATIONS	190.01	43,482	45,443	1.00
	TOTALS		43,482	45,443	
C - RECLASS RADIOLOGY EXPENSE					
1.00	CHEMICAL DEPENDENCY/SAFE	31.01	0	5,137	1.00
	TOTALS		0	5,137	
E - TO RECLASS INTEREST EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	49,909	1.00
	TOTALS		0	49,909	
F - RECLASS LEASES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,143,854	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	78,478	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
	TOTALS		0	2,222,332	
G - RECLASS MISC COSTS TO ADMIN					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	42,311	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	457,345	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
	TOTALS		0	499,656	
H - TO RECLASS LIGHT DUTY WAGES					
1.00	NURSING ADMINISTRATION	13.00	16,993	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	5,649	0	2.00
	TOTALS		22,642	0	
I - TO RECLASSIFY ORIENTATION WAGES					
1.00	ADULTS & PEDIATRICS	30.00	170,834	0	1.00
	TOTALS		170,834	0	
J - TO RECLASS GEN LIAB INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	34,868	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	121,905	2.00
	TOTALS		0	156,773	
K - TO RECLASS PROPERTY TAX					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	74,029	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	258,822	2.00
	TOTALS		0	332,851	
L - DEFAULT					
1.00		0.00	0	0	1.00
	TOTALS		0	0	
500.00	Grand Total: Increases		236,958	3,328,564	500.00

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7	Ref.	
6.00		7.00	8.00	9.00	10.00		
A - RECLASS LAB COSTS							
1.00	ADULTS & PEDIATRICS	30.00	0	16,463	0		1.00
	TOTALS		0	16,463			
B - RECLASS COMMUNITY RELATIONS							
1.00	ADMINISTRATIVE & GENERAL	5.00	43,482	45,443	0		1.00
	TOTALS		43,482	45,443			
C - RECLASS RADIOLOGY EXPENSE							
1.00	ADULTS & PEDIATRICS	30.00	0	5,137	0		1.00
	TOTALS		0	5,137			
E - TO RECLASS INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	49,909	0		1.00
	TOTALS		0	49,909			
F - RECLASS LEASES							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	436	14		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,684,844	14		2.00
3.00	MAINTENANCE & REPAIRS	6.00	0	14,672	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	671	0		4.00
5.00	CHEMICAL DEPENDENCY/SAFE	31.01	0	1	0		5.00
6.00	CLINIC	90.00	0	498,338	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	7,138	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	16,232	0		8.00
	TOTALS		0	2,222,332			
G - RECLASS MISC COSTS TO ADMIN							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	153	0		1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	13	0		2.00
3.00	NURSING ADMINISTRATION	13.00	0	84	0		3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	464	0		4.00
5.00	SOCIAL SERVICE	17.00	0	208	0		5.00
6.00	CLINIC	90.00	0	41,101	0		6.00
7.00	RETAIL PHARMACY	190.02	0	288	0		7.00
8.00	CLINIC	90.00	0	457,345	0		8.00
	TOTALS		0	499,656			
H - TO RECLASS LIGHT DUTY WAGES							
1.00	ADMINISTRATIVE & GENERAL	5.00	22,642	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		22,642	0			
I - TO RECLASSIFY ORIENTATION WAGES							
1.00	ADMINISTRATIVE & GENERAL	5.00	170,834	0	0		1.00
	TOTALS		170,834	0			
J - TO RECLASS GEN LIAB INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	156,773	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	156,773			
K - TO RECLASS PROPERTY TAX							
1.00	OTHER CAP REL COSTS	3.00	0	332,851	13		1.00
2.00		0.00	0	0	13		2.00
	TOTALS		0	332,851			
L - DEFAULT							
1.00		0.00	0	0	0		1.00
	TOTALS		0	0			
500.00	Grand Total: Decreases		236,958	3,328,564			500.00

Increases			Decreases			
Cost Center	Line #	Salary	Cost Center	Line #	Salary	
2.00	3.00	4.00	6.00	7.00	8.00	
A - RECLASS LAB COSTS						
1.00	CHEMICAL DEPENDENCY/SAFE	31.01	0ADULTS & PEDIATRICS	30.00	0	1.00
	TOTALS		0TOTALS		0	
B - RECLASS COMMUNITY RELATIONS						
1.00	COMMUNITY RELATIONS	190.01	43,482ADMINISTRATIVE & GENERAL	5.00	43,482	1.00
	TOTALS	43,482	TOTALS		43,482	
C - RECLASS RADIOLOGY EXPENSE						
1.00	CHEMICAL DEPENDENCY/SAFE	31.01	0ADULTS & PEDIATRICS	30.00	0	1.00
	TOTALS		0TOTALS		0	
E - TO RECLASS INTEREST EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0INTEREST EXPENSE	113.00	0	1.00
	TOTALS		0TOTALS		0	
F - RECLASS LEASES						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0ADMINISTRATIVE & GENERAL	5.00	0	2.00
3.00		0.00	0MAINTENANCE & REPAIRS	6.00	0	3.00
4.00		0.00	0ADULTS & PEDIATRICS	30.00	0	4.00
5.00		0.00	0CHEMICAL DEPENDENCY/SAFE	31.01	0	5.00
6.00		0.00	0CLINIC	90.00	0	6.00
7.00		0.00	0NURSING ADMINISTRATION	13.00	0	7.00
8.00		0.00	0MEDICAL RECORDS & LIBRARY	16.00	0	8.00
	TOTALS		0TOTALS		0	
G - RECLASS MISC COSTS TO ADMIN.						
1.00	ADMINISTRATIVE & GENERAL	5.00	0EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0MAINTENANCE & REPAIRS	6.00	0	2.00
3.00		0.00	0NURSING ADMINISTRATION	13.00	0	3.00
4.00		0.00	0MEDICAL RECORDS & LIBRARY	16.00	0	4.00
5.00		0.00	0SOCIAL SERVICE	17.00	0	5.00
6.00		0.00	0CLINIC	90.00	0	6.00
7.00		0.00	0RETAIL PHARMACY	190.02	0	7.00
8.00		0.00	0CLINIC	90.00	0	8.00
	TOTALS		0TOTALS		0	
H - TO RECLASS LIGHT DUTY WAGES						
1.00	NURSING ADMINISTRATION	13.00	16,993ADMINISTRATIVE & GENERAL	5.00	22,642	1.00
2.00	ADULTS & PEDIATRICS	30.00	5,649	0.00	0	2.00
	TOTALS	22,642	TOTALS		22,642	
I - TO RECLASSIFY ORIENTATION WAGES						
1.00	ADULTS & PEDIATRICS	30.00	170,834ADMINISTRATIVE & GENERAL	5.00	170,834	1.00
	TOTALS	170,834	TOTALS		170,834	
J - TO RECLASS GEN LIAB INSURANCE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0ADMINISTRATIVE & GENERAL	5.00	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	0.00	0	2.00
	TOTALS		0TOTALS		0	
K - TO RECLASS PROPERTY TAX						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0OTHER CAP REL COSTS	3.00	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	0.00	0	2.00
	TOTALS		0TOTALS		0	
L - DEFAULT						
1.00		0.00	0	0.00	0	1.00
	TOTALS		0TOTALS		0	
500.00	Grand Total: Increases		236,958	Grand Total: Decreases		236,958 500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 264012

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

Worksheet A-7
Part I
Date/Time Prepared:
5/29/2014 3:14 pm

		Acquisitions				Disposals and Retirements	
		Beginning Balances	Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	1,037,477	208,269	0	208,269	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	4,183,716	227,129	0	227,129	55,444	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	5,221,193	435,398	0	435,398	55,444	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	5,221,193	435,398	0	435,398	55,444	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	1,245,746	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	4,355,401	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	5,601,147	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	5,601,147	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 264012

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

Worksheet A-7
Part II
Date/Time Prepared:
5/29/2014 3:14 pm

		SUMMARY OF CAPITAL					
Cost Center Description		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	109,082	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	572,734	0	0	7,634	0	2.00
3.00	Total (sum of lines 1-2)	681,816	0	0	7,634	0	3.00
		SUMMARY OF CAPITAL					
Cost Center Description		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	109,082				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	580,368				2.00
3.00	Total (sum of lines 1-2)	0	689,450				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 264012

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

Worksheet A-7
Part III
Date/Time Prepared:
5/29/2014 3:14 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	1,245,746	0	1,245,746	0.222409	0
2.00	CAP REL COSTS-MVBLE EQUIP	4,355,401	0	4,355,401	0.777591	0
3.00	Total (sum of lines 1-2)	5,601,147	0	5,601,147	1.000000	0
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	109,082	0
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	572,734	0
3.00	Total (sum of lines 1-2)	0	0	0	681,816	0
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	0	34,868	74,029	2,143,854	2,361,833
2.00	CAP REL COSTS-MVBLE EQUIP	0	129,539	258,822	78,478	1,039,573
3.00	Total (sum of lines 1-2)	0	164,407	332,851	2,222,332	3,401,406

		Expense Classification on Worksheet A To/From which the Amount is to be Adjusted				
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0 CAP REL COSTS-BLDG & FIXT	1.00	0 1.00	
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0 CAP REL COSTS-MVBLE EQUIP	2.00	0 2.00	
3.00 Investment income - other (chapter 2)	B	-9,449	ADMINISTRATIVE & GENERAL	5.00	0 3.00	
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0 4.00	
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0 5.00	
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0 6.00	
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	0 7.00	
8.00 Television and radio service (chapter 21)		0		0.00	0 8.00	
9.00 Parking lot (chapter 21)		0		0.00	0 9.00	
10.00 Provider-based physician adjustment	A-8-2	-3,414,348			0 10.00	
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0 11.00	
12.00 Related organization transactions (chapter 10)	A-8-1	0			0 12.00	
13.00 Laundry and linen service		0		0.00	0 13.00	
14.00 Cafeteria-employees and guests	B	-81,608	CAFETERIA	11.00	0 14.00	
15.00 Rental of quarters to employee and others		0		0.00	0 15.00	
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0 16.00	
17.00 Sale of drugs to other than patients		0		0.00	0 17.00	
18.00 Sale of medical records and abstracts	B	-845	MEDICAL RECORDS & LIBRARY	16.00	0 18.00	
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0 19.00	
20.00 Vending machines	A	-258	MAINTENANCE & REPAIRS	6.00	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	*** Cost Center Deleted ***	65.00	23.00	
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	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	0 CAP REL COSTS-BLDG & FIXT	1.00	0 26.00	
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	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	*** Cost Center Deleted ***	67.00	30.00	
30.99 Hospice (non-distinct) (see instructions)		0	0 ADULTS & PEDIATRICS	30.00	30.99	
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00	31.00	
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0 32.00	
33.00 SBH SERV AGREEMENT	B	-42,604	ADMINISTRATIVE & GENERAL	5.00	0 33.00	
33.01 LOBBYING EXPENSE PER MHA	A	-4,860	ADMINISTRATIVE & GENERAL	5.00	0 33.01	

Provider CCN: 264012

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

Worksheet A-8

Date/Time Prepared:
 5/29/2014 3:14 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on worksheet A To/From which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.
				Cost Center			
		1.00	2.00	3.00	4.00	5.00	
33.02	FRA EXPENSE	B	2,225,159	ADMINISTRATIVE & GENERAL		5.00	0 33.02
33.03	TRANSPORTATION EXPENSE	A	-108,059	ADMINISTRATIVE & GENERAL		5.00	0 33.03
33.04	BAD DEBT EXPENSE	A	-2,754,780	ADMINISTRATIVE & GENERAL		5.00	0 33.04
33.05	CD EDUCATIONAL INCOME	B	-150	CHEMICAL DEPENDENCY/SAFE		31.01	0 33.05
33.06	GAIN ON SALE	B	-1,600	ADMINISTRATIVE & GENERAL		5.00	0 33.06
33.07	DONATIONS	B	-23,773	ADMINISTRATIVE & GENERAL		5.00	0 33.07
33.08	OTHER INCOME	B	-102,914	ADMINISTRATIVE & GENERAL		5.00	0 33.08
33.09	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.09
33.10	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.10
33.11	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.11
33.12	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.12
33.13	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.13
33.14	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.14
33.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.15
33.16	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.16
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-4,320,089				50.00

1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00
1.00	5.00 ADMINISTRATIVE & GENERAL	1,417,014	1,417,014	0	0	0	1.00
2.00	30.00 ADULTS & PEDIATRICS	866,979	866,979	0	0	0	2.00
3.00	31.01 CHEMICAL DEPENDENCY/SAFE	241,000	241,000	0	0	0	3.00
4.00	90.00 CLINIC	889,355	889,355	0	0	0	4.00
5.00	0.00	0	0	0	0	0	5.00
6.00	0.00	0	0	0	0	0	6.00
7.00	0.00	0	0	0	0	0	7.00
8.00	0.00	0	0	0	0	0	8.00
9.00	0.00	0	0	0	0	0	9.00
10.00	0.00	0	0	0	0	0	10.00
200.00		3,414,348	3,414,348	0	0	0	200.00

8.00	9.00	12.00	13.00	14.00	
1.00	5.00 ADMINISTRATIVE & GENERAL	0	0	0	1.00
2.00	30.00 ADULTS & PEDIATRICS	0	0	0	2.00
3.00	31.01 CHEMICAL DEPENDENCY/SAFE	0	0	0	3.00
4.00	90.00 CLINIC	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
10.00	0.00	0	0	0	10.00
200.00		0	0	0	200.00

15.00	16.00	17.00	18.00	
1.00	5.00 ADMINISTRATIVE & GENERAL	0	1,417,014	1.00
2.00	30.00 ADULTS & PEDIATRICS	0	866,979	2.00
3.00	31.01 CHEMICAL DEPENDENCY/SAFE	0	241,000	3.00
4.00	90.00 CLINIC	0	889,355	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
200.00		0	3,414,348	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 264012

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2014 3:14 pm

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,361,833	2,361,833			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,039,573		1,039,573		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	5,010,865	32,309	14,221	5,057,395	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	7,143,302	281,789	124,031	802,094	8,351,216 5.00
6.00 00600	MAINTENANCE & REPAIRS	811,814	68,545	30,170	69,295	979,824 6.00
8.00 00800	LAUNDRY & LINEN SERVICE	99,907	8,726	3,841	0	112,474 8.00
9.00 00900	HOUSEKEEPING	417,093	17,112	7,532	0	441,737 9.00
10.00 01000	DIETARY	1,196,569	75,937	33,424	91,580	1,397,510 10.00
11.00 01100	CAFETERIA	-81,608	96,006	42,258	0	56,656 11.00
13.00 01300	NURSING ADMINISTRATION	791,918	14,688	6,465	228,290	1,041,361 13.00
15.00 01500	PHARMACY	862,396	30,225	13,304	13,571	919,496 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	582,028	13,573	5,974	115,091	716,666 16.00
17.00 01700	SOCIAL SERVICE	549,861	38,102	16,771	159,273	764,007 17.00
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0 18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	7,635,439	718,725	316,350	2,000,332	10,670,846 30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
31.01 03101	CHEMICAL DEPENDENCY/SAFE	1,598,563	256,897	113,075	393,697	2,362,232 31.01
ANCILLARY SERVICE COST CENTERS						
70.00 07000	ELECTROENCEPHALOGRAPHY	412,081	41,786	18,392	42,880	515,139 70.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	5,554,686	644,024	283,470	1,061,564	7,543,744 90.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	35,986,320	2,338,444	1,029,278	4,977,667	35,872,908 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
190.01 19001	COMMUNITY RELATIONS	88,925	1,454	640	12,749	103,768 190.01
190.02 19002	RETAIL PHARMACY	1,425,560	21,935	9,655	66,979	1,524,129 190.02
200.00	Cross Foot Adjustments					0 200.00
201.00	Negative Cost Centers					0 201.00
202.00	TOTAL (sum lines 118-201)	37,500,805	2,361,833	1,039,573	5,057,395	37,500,805 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 264012

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2014 3:14 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	8,351,216					5.00
6.00	00600	280,715	1,260,539				6.00
8.00	00800	32,223	6,650	151,347			8.00
9.00	00900	126,555	13,042	0	581,334		9.00
10.00	01000	400,380	57,877	0	27,115	1,882,882	10.00
11.00	01100	16,232	73,172	0	34,281	389,265	11.00
13.00	01300	298,345	11,195	0	5,245	0	13.00
15.00	01500	263,431	23,036	0	10,792	0	15.00
16.00	01600	205,321	10,345	0	4,847	0	16.00
17.00	01700	218,884	29,040	0	13,605	0	17.00
18.00	01850	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	3,057,148	547,787	124,932	256,637	1,099,927	30.00
31.00	03100	0	0	0	0	0	31.00
31.01	03101	676,768	195,798	26,415	91,731	215,200	31.01
ANCILLARY SERVICE COST CENTERS							
70.00	07000	147,585	31,848	0	14,921	0	70.00
73.00	07300	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	2,161,245	242,923	0	113,809	178,490	90.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		7,884,832	1,242,713	151,347	572,983	1,882,882	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	29,729	1,108	0	519	0	190.01
190.02	19002	436,655	16,718	0	7,832	0	190.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		8,351,216	1,260,539	151,347	581,334	1,882,882	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 264012

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2014 3:14 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11.00	13.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	569,606					11.00
13.00	01300	28,977	1,385,123				13.00
15.00	01500	8,049	0	1,224,804			15.00
16.00	01600	28,172	0	0	965,351		16.00
17.00	01700	28,977	0	0	0	1,054,513	17.00
18.00	01850	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	335,109	1,143,377	0	905,016	965,147	30.00
31.00	03100	0	0	0	0	0	31.00
31.01	03101	75,661	241,746	0	50,279	89,366	31.01
ANCILLARY SERVICE COST CENTERS							
70.00	07000	7,244	0	0	0	0	70.00
73.00	07300	0	0	1,224,804	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	57,417	0	0	10,056	0	90.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		569,606	1,385,123	1,224,804	965,351	1,054,513	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	0	0	0	0	0	190.01
190.02	19002	0	0	0	0	0	190.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		569,606	1,385,123	1,224,804	965,351	1,054,513	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 264012

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2014 3:14 pm

Cost Center Description		OTHER GENERAL SERVICE (SPECIFY)	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		18.00	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
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0			18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	19,105,926	0	19,105,926
31.00	03100	INTENSIVE CARE UNIT	0	0	0	31.00
31.01	03101	CHEMICAL DEPENDENCY/SAFE	0	4,025,196	0	4,025,196
ANCILLARY SERVICE COST CENTERS						
70.00	07000	ELECTROENCEPHALOGRAPHY	0	716,737	0	716,737
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,224,804	0	1,224,804
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	10,307,684	0	10,307,684
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	35,380,347	0	35,380,347
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
190.01	19001	COMMUNITY RELATIONS	0	135,124	0	135,124
190.02	19002	RETAIL PHARMACY	0	1,985,334	0	1,985,334
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	37,500,805	0	37,500,805

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	4	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
6.00	MAINTENANCE & REPAIRS	2	SQUARE FEET	6.00
8.00	LAUNDRY & LINEN SERVICE	3	PATIENT DAYS	8.00
9.00	HOUSEKEEPING	2	SQUARE FEET	9.00
10.00	DIETARY	10	MEALS SERVED	10.00
11.00	CAFETERIA	6	PAID FTE'S	11.00
13.00	NURSING ADMINISTRATION	3	PATIENT DAYS	13.00
15.00	PHARMACY	7	PERCENT	15.00
16.00	MEDICAL RECORDS & LIBRARY	16	TIME SPENT	16.00
17.00	SOCIAL SERVICE	17	TIME SPENT	17.00
18.00	OTHER GENERAL SERVICE (SPECIFY)	18	TIME SPENT	18.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 264012

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

Worksheet B Part II Date/Time Prepared: 5/29/2014 3:14 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT
		BLDG & FIXT	MVBLE EQUIP		
	0	1.00	2.00	2A	4.00
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	32,309	14,221	46,530	46,530 4.00
5.00 00500 ADMINISTRATIVE & GENERAL	0	281,789	124,031	405,820	7,378 5.00
6.00 00600 MAINTENANCE & REPAIRS	0	68,545	30,170	98,715	637 6.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	8,726	3,841	12,567	0 8.00
9.00 00900 HOUSEKEEPING	0	17,112	7,532	24,644	0 9.00
10.00 01000 DIETARY	0	75,937	33,424	109,361	842 10.00
11.00 01100 CAFETERIA	0	96,006	42,258	138,264	0 11.00
13.00 01300 NURSING ADMINISTRATION	0	14,688	6,465	21,153	2,100 13.00
15.00 01500 PHARMACY	0	30,225	13,304	43,529	125 15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	13,573	5,974	19,547	1,059 16.00
17.00 01700 SOCIAL SERVICE	0	38,102	16,771	54,873	1,465 17.00
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0 18.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS	0	718,725	316,350	1,035,075	18,410 30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0 31.00
31.01 03101 CHEMICAL DEPENDENCY/SAFE	0	256,897	113,075	369,972	3,622 31.01
ANCILLARY SERVICE COST CENTERS					
70.00 07000 ELECTROENCEPHALOGRAPHY	0	41,786	18,392	60,178	394 70.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0	644,024	283,470	927,494	9,765 90.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE					113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	2,338,444	1,029,278	3,367,722	45,797 118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
190.01 19001 COMMUNITY RELATIONS	0	1,454	640	2,094	117 190.01
190.02 19002 RETAIL PHARMACY	0	21,935	9,655	31,590	616 190.02
200.00 Cross Foot Adjustments				0	200.00
201.00 Negative Cost Centers		0	0	0	0 201.00
202.00 TOTAL (sum lines 118-201)	0	2,361,833	1,039,573	3,401,406	46,530 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 264012

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2014 3:14 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	413,198					5.00
6.00	00600	13,889	113,241				6.00
8.00	00800	1,594	597	14,758			8.00
9.00	00900	6,262	1,172	0	32,078		9.00
10.00	01000	19,810	5,199	0	1,496	136,708	10.00
11.00	01100	803	6,573	0	1,892	28,263	11.00
13.00	01300	14,761	1,006	0	289	0	13.00
15.00	01500	13,034	2,069	0	596	0	15.00
16.00	01600	10,159	929	0	267	0	16.00
17.00	01700	10,830	2,609	0	751	0	17.00
18.00	01850	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	151,260	49,211	12,182	14,161	79,861	30.00
31.00	03100	0	0	0	0	0	31.00
31.01	03101	33,485	17,590	2,576	5,062	15,625	31.01
ANCILLARY SERVICE COST CENTERS							
70.00	07000	7,302	2,861	0	823	0	70.00
73.00	07300	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	106,933	21,823	0	6,280	12,959	90.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00							118.00
		390,122	111,639	14,758	31,617	136,708	
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	1,471	100	0	29	0	190.01
190.02	19002	21,605	1,502	0	432	0	190.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		413,198	113,241	14,758	32,078	136,708	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 264012

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2014 3:14 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11.00	13.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	153,765					11.00
13.00	01300	7,822	47,131				13.00
15.00	01500	2,173	0	61,526			15.00
16.00	01600	7,605	0	0	39,566		16.00
17.00	01700	7,822	0	0	0	78,350	17.00
18.00	01850	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	90,462	38,905	0	37,093	71,710	30.00
31.00	03100	0	0	0	0	0	31.00
31.01	03101	20,425	8,226	0	2,061	6,640	31.01
ANCILLARY SERVICE COST CENTERS							
70.00	07000	1,956	0	0	0	0	70.00
73.00	07300	0	0	61,526	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	15,500	0	0	412	0	90.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		153,765	47,131	61,526	39,566	78,350	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	0	0	0	0	0	190.01
190.02	19002	0	0	0	0	0	190.02
200.00							200.00
201.00		22,030	0	0	0	0	201.00
202.00		175,795	47,131	61,526	39,566	78,350	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 264012

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		OTHER GENERAL SERVICE (SPECIFY)	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		18.00	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
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0			18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,598,330	0	1,598,330
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0
31.01	03101	CHEMICAL DEPENDENCY/SAFE	0	485,284	0	485,284
ANGILLARY SERVICE COST CENTERS						
70.00	07000	ELECTROENCEPHALOGRAPHY	0	73,514	0	73,514
73.00	07300	DRUGS CHARGED TO PATIENTS	0	61,526	0	61,526
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,101,166	0	1,101,166
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,319,820	0	3,319,820
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0
190.01	19001	COMMUNITY RELATIONS	0	3,811	0	3,811
190.02	19002	RETAIL PHARMACY	0	55,745	0	55,745
200.00		Cross Foot Adjustments	0	0	0	0
201.00		Negative Cost Centers	0	22,030	0	22,030
202.00		TOTAL (sum lines 118-201)	0	3,401,406	0	3,401,406

Cost Center Description	CAPITAL RELATED COSTS			Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)			
	1.00	2.00	4.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	97,444				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		97,444			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,333	1,333	17,249,474		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	11,626	11,626	2,735,738	-8,351,216	29,149,589 5.00
6.00 00600	MAINTENANCE & REPAIRS	2,828	2,828	236,349	0	979,824 6.00
8.00 00800	LAUNDRY & LINEN SERVICE	360	360	0	0	112,474 8.00
9.00 00900	HOUSEKEEPING	706	706	0	0	441,737 9.00
10.00 01000	DIETARY	3,133	3,133	312,357	0	1,397,510 10.00
11.00 01100	CAFETERIA	3,961	3,961	0	0	56,656 11.00
13.00 01300	NURSING ADMINISTRATION	606	606	778,638	0	1,041,361 13.00
15.00 01500	PHARMACY	1,247	1,247	46,287	0	919,496 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	560	560	392,547	0	716,666 16.00
17.00 01700	SOCIAL SERVICE	1,572	1,572	543,241	0	764,007 17.00
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0 18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	29,653	29,653	6,822,609	0	10,670,846 30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
31.01 03101	CHEMICAL DEPENDENCY/SAFE	10,599	10,599	1,342,801	0	2,362,232 31.01
ANCILLARY SERVICE COST CENTERS						
70.00 07000	ELECTROENCEPHALOGRAPHY	1,724	1,724	146,253	0	515,139 70.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	26,571	26,571	3,620,725	0	7,543,744 90.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	96,479	96,479	16,977,545	-8,351,216	27,521,692 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
190.01 19001	COMMUNITY RELATIONS	60	60	43,482	0	103,768 190.01
190.02 19002	RETAIL PHARMACY	905	905	228,447	0	1,524,129 190.02
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)	2,361,833	1,039,573	5,057,395		8,351,216 202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	24.237849	10.668415	0.293191		0.286495 203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			46,530		413,198 204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.002697		0.014175 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 264012

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (PAID FEE'S)	
		6.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	68,236					6.00
8.00	00800	360	35,438				8.00
9.00	00900	706	0	67,170			9.00
10.00	01000	3,133	0	3,133	150,228		10.00
11.00	01100	3,961	0	3,961	31,058	2,123	11.00
13.00	01300	606	0	606	0	108	13.00
15.00	01500	1,247	0	1,247	0	30	15.00
16.00	01600	560	0	560	0	105	16.00
17.00	01700	1,572	0	1,572	0	108	17.00
18.00	01850	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	29,653	29,253	29,653	87,759	1,249	30.00
31.00	03100	0	0	0	0	0	31.00
31.01	03101	10,599	6,185	10,599	17,170	282	31.01
ANCILLARY SERVICE COST CENTERS							
70.00	07000	1,724	0	1,724	0	27	70.00
73.00	07300	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	13,150	0	13,150	14,241	214	90.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		67,271	35,438	66,205	150,228	2,123	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	60	0	60	0	0	190.01
190.02	19002	905	0	905	0	0	190.02
200.00							200.00
201.00							201.00
202.00		1,260,539	151,347	581,334	1,882,882	569,606	202.00
203.00		18.473225	4.270755	8.654667	12.533496	268.302402	203.00
204.00		113,241	14,758	32,078	136,708	175,795	204.00
205.00		1.659549	0.416446	0.477564	0.910003	72.428168	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 264012

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

Worksheet B-1
Date/Time Prepared:
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Cost Center Description		NURSING ADMINISTRATION (PATIENT DAYS)	PHARMACY (PERCENT)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY) (TIME SPENT)	
		13.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	35,438					13.00
15.00	01500	0	100				15.00
16.00	01600	0	0	96			16.00
17.00	01700	0	0	0	118		17.00
18.00	01850	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	29,253	0	90	108	0	30.00
31.00	03100	0	0	0	0	0	31.00
31.01	03101	6,185	0	5	10	0	31.01
ANCILLARY SERVICE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
73.00	07300	0	100	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	1	0	0	90.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		35,438	100	96	118	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	0	0	0	0	0	190.01
190.02	19002	0	0	0	0	0	190.02
200.00							200.00
201.00							201.00
202.00		1,385,123	1,224,804	965,351	1,054,513	0	202.00
203.00		39.085812	12,248.040000	10,055.739583	8,936.550847	0.000000	203.00
204.00		47,131	61,526	39,566	78,350	0	204.00
205.00		1.329957	615.260000	412.145833	663.983051	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 264012

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

Worksheet C
Part I
Date/Time Prepared:
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Title XVIII

Hospital

PPS

Cost Center Description	Total Cost (From Wkst. 8, Part I, col. 26)	Therapy Limit Adj.	Total costs	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		19,105,926	0		19,105,926	30.00
31.00	03100 INTENSIVE CARE UNIT		0	0	0	0	31.00
31.01	03101 CHEMICAL DEPENDENCY/SAFE		4,025,196	0		4,025,196	31.01
ANCILLARY SERVICE COST CENTERS							
70.00	07000 ELECTROENCEPHALOGRAPHY		716,737	0		716,737	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS		1,224,804	0		1,224,804	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC		10,307,684	0		10,307,684	90.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	0	35,380,347	0		35,380,347	200.00
201.00	Less Observation Beds	0	0	0		0	201.00
202.00	Total (see instructions)	0	35,380,347	0		35,380,347	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 264012

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

Worksheet C
Part I
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		Title XVIII			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	25,618,592		25,618,592		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
31.01	03101	CHEMICAL DEPENDENCY/SAFE	3,495,000		3,495,000		31.01
ANCILLARY SERVICE COST CENTERS							
70.00	07000	ELECTROENCEPHALOGRAPHY	1,212,568	2,248,372	3,460,940	0.207093	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,686,342	198,942	3,885,284	0.315242	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	83,270	40,677,541	40,760,811	0.252882	90.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	34,095,772	43,124,855	77,220,627		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	34,095,772	43,124,855	77,220,627		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 264012

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

worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
31.01	03101 CHEMICAL DEPENDENCY/SAFE				31.01
ANCILLARY SERVICE COST CENTERS					
70.00	07000 ELECTROENCEPHALOGRAPHY	0.207093			70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.315242			73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.252882			90.00
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: 264012

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

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		Title XIX		Hospital		Cost	
Cost Center Description		Total Cost (from wkst. B, Part I, col 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	19,105,926		19,105,926	0	19,105,926	30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0	31.00
31.01	03101 CHEMICAL DEPENDENCY/SAFE	4,025,196		4,025,196	0	4,025,196	31.01
ANCILLARY SERVICE COST CENTERS							
70.00	07000 ELECTROENCEPHALOGRAPHY	716,737		716,737	0	716,737	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,224,804		1,224,804	0	1,224,804	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	10,307,684		10,307,684	0	10,307,684	90.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	35,380,347	0	35,380,347	0	35,380,347	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	35,380,347	0	35,380,347	0	35,380,347	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 264012

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	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	25,618,592		25,618,592		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
31.01	03101	CHEMICAL DEPENDENCY/SAFE	3,495,000		3,495,000		31.01
ANCILLARY SERVICE COST CENTERS							
70.00	07000	ELECTROENCEPHALOGRAPHY	1,212,568	2,248,372	3,460,940	0.207093	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,686,342	198,942	3,885,284	0.315242	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	83,270	40,677,541	40,760,811	0.252882	90.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	34,095,772	43,124,855	77,220,627		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	34,095,772	43,124,855	77,220,627		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 264012

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2014 3:14 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
INPATIENT ROUTINE SERVICE COST CENTERS		11.00			
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
31.01	03101 CHEMICAL DEPENDENCY/SAFE				31.01
ANCILLARY SERVICE COST CENTERS					
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
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: 264012

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

Worksheet D
Part I
Date/Time Prepared:
5/29/2014 3:14 pm

		Title XVIII		Hospital	PPS		
Cost Center Description		Capital Related Cost (From WKST. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,598,330	0	1,598,330	29,253	54.64	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
31.01	CHEMICAL DEPENDENCY/SAFE	485,284		485,284	6,185	78.46	31.01
200.00	Total (lines 30-199)	2,083,614		2,083,614	35,438		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	8,550	467,172				
31.00	INTENSIVE CARE UNIT	0	0				
31.01	CHEMICAL DEPENDENCY/SAFE	0	0				
200.00	Total (lines 30-199)	8,550	467,172				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 264012

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

Worksheet D
Part II
Date/Time Prepared:
5/29/2014 3:14 pm

Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 = col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
70.00	07000	ELECTROENCEPHALOGRAPHY	73,514	3,460,940	0.021241	833,003	17,694	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	61,526	3,885,284	0.015836	1,484,501	23,509	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,101,166	40,760,811	0.027015	83,270	2,250	90.00
200.00		Total (lines 50-199)	1,236,206	48,107,035		2,400,774	43,453	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 264012

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

Worksheet D
Part III
Date/Time Prepared:
5/29/2014 3:14 pm

		Title XVIII			Hospital	PPS	
Cost Center Description		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
31.01	03101	CHEMICAL DEPENDENCY/SAFE	0	0	0	0	31.01
200.00		Total (lines 30-199)	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	29,253	0.00	8,550	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0.00	0	0	31.00
31.01	03101	CHEMICAL DEPENDENCY/SAFE	6,185	0.00	0	0	31.01
200.00		Total (lines 30-199)	35,438		8,550	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
31.01	03101	CHEMICAL DEPENDENCY/SAFE	0	0			31.01
200.00		Total (lines 30-199)	0	0			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 264012

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2014 3:14 pm

Cost Center Description	Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
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: 264012

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2014 3:14 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,460,940	0.000000	0.000000	833,003	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,885,284	0.000000	0.000000	1,484,501	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	40,760,811	0.000000	0.000000	83,270	90.00
200.00		Total (lines 50-199)	0	48,107,035			2,400,774	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 264012

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

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital PSA Adj. Non-Physician Anesthetist Cost	PPS PSA Adj. Nursing School	
11.00			12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
70.00	07000 ELECTROENCEPHALOGRAPHY	0	901,626	0	0	0	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	5,807	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	19,413,990	0	0	0	90.00
200.00	Total (lines 50-199)	0	20,321,423	0	0	0	200.00

APPORIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 264012

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

worksheet D
Part IV
Date/Time Prepared:
5/29/2014 3:14 pm

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XVIII	Hospital	PPS
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0			70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0			90.00
200.00	Total (lines 50-199)	0	0			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 264012

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

Worksheet D
Part V
Date/Time Prepared:
5/29/2014 3:14 pm

		Title XVIII		Hospital		PPS	
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part 1, col. 9	Charges		Costs		PPS Services (see inst.)	
		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							
70.00	07000 ELECTROENCEPHALOGRAPHY	0.207093	901,626	0	0	186,720	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.315242	5,807	0	0	1,831	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.252882	19,413,990	0	0	4,909,449	90.00
200.00	Subtotal (see instructions)		20,321,423	0	0	5,098,000	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		20,321,423	0	0	5,098,000	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 264012

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

Worksheet D
Part V
Date/Time Prepared:
5/29/2014 3:14 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				
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
200.00 Subtotal (see instructions)	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 264012

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

worksheet D-1

Date/Time Prepared:
5/29/2014 3:14 pm

Title XVIII

Hospital

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)	29,253	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	29,253	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)	29,253	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)	8,550	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)	19,105,926	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)	19,105,926	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)	19,105,926	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)	653.13	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5,584,262	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	5,584,262	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 264012

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

Worksheet D-1

Date/Time Prepared:
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Cost Center Description		Total Inpatient Cost	Total Inpatient Days/Diem	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)						42.00
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
43.01	CHEMICAL DEPENDENCY/SAFE	4,025,196	6,185	650.80	0	0	43.01
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)					661,543	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,245,805	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)					467,172	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					43,453	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					510,625	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					5,735,180	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: 264012

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

Worksheet D-1

Date/Time Prepared:
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Cost Center Description	Cost	Title XVIII		Hospital	PPS	
		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	1,598,330	19,105,926	0.083656	0	0	90.00
91.00 Nursing School cost	0	19,105,926	0.000000	0	0	91.00
92.00 Allied health cost	0	19,105,926	0.000000	0	0	92.00
93.00 All other Medical Education	0	19,105,926	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 264012

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

Worksheet D-1

Date/Time Prepared:
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Title XIX		Hospital	Cost
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	29,253	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	29,253	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)	29,253	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)	3,697	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)	19,105,926	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)	19,105,926	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)	19,105,926	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)	653.13	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,414,622	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,414,622	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 264012

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

Worksheet D-1

Date/Time Prepared:
5/29/2014 3:14 pm

Cost Center Description	Title XIX			Hospital	Cost
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	43.00
43.01 CHEMICAL DEPENDENCY/SAFE	4,025,196	6,185	650.80	0	43.01
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)					73,384
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,488,006
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0
52.00 Total Program excludable cost (sum of lines 50 and 51)					0
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00 Relief payment (see instructions)					0
63.00 Allowable inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
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
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
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 264012

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

Worksheet D-1
Date/Time Prepared:
5/29/2014 3:14 pm

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 264012

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

Worksheet D-3

Date/Time Prepared:
5/29/2014 3:14 pm

Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		7,577,640		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
31.01	03101 CHEMICAL DEPENDENCY/SAFE		0		31.01
ANCILLARY SERVICE COST CENTERS					
70.00	07000 ELECTROENCEPHALOGRAPHY	0.207093	833,003	172,509	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.315242	1,484,501	467,977	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.252882	83,270	21,057	90.00
200.00	Total (sum of lines 50-94 and 96-98)		2,400,774	661,543	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		2,400,774		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 264012

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

Worksheet D-3

Date/Time Prepared:
5/29/2014 3:14 pm

Cost Center Description		Ratio of Cost to Charges	Hospital 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		3,253,360		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
31.01	03101 CHEMICAL DEPENDENCY/SAFE		0		31.01
ANCILLARY SERVICE COST CENTERS					
70.00	07000 ELECTROENCEPHALOGRAPHY	0.207093	0	0	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.315242	232,787	73,384	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.252882	0	0	90.00
200.00	Total (sum of lines 50-94 and 96-98)		232,787	73,384	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)		232,787		202.00

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 264012

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

Worksheet DSH
Date/Time Prepared:
5/29/2014 3:14 pm

		Title XVIII			Hospital	PPS	
		Original mcaX 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)	0.00	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	20.91	0.00			20.91	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	20.91	0.00			20.91	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)	148.00	0.00			148.00	5.00
6.00	Disproportionate Share Payment Percentage (transfer to worksheet E, Part A, line 33)	0.00	0.00			6.47	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	No				No	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	No				No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (worksheet L, Part I, line 1 greater than -0-)	No				No	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	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)	3,697	0			3,697	15.00
16.00	In-State Medicaid eligible unpaid paid days (worksheet S-2, line 24, column 2)	0	0			0	16.00
17.00	Out-of-State Medicaid paid days (worksheet S-2, line 24, column 3)	1,832	0			1,832	17.00
18.00	Out-of-State Medicaid eligible unpaid days (worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (worksheet S-2, line 24, column 5)	1,882	0			1,882	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)	7,411	0			7,411	21.00
22.00	Total patient days (worksheet S-3, Part I, Column 8, Line 14)	35,438	0			35,438	22.00
23.00	Plus total labor room days (worksheet S-3, Part I, Column 8, Line 32)	0	0			0	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)	35,438	0			35,438	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	20.91	0.00			20.91	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 264012	Period: From 01/01/2013 To 12/31/2013	Worksheet DSH Date/Time Prepared: 5/29/2014 3:14 pm
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	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	6.47	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		6.47	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.		6.47	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 ammendment? (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: 264012

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

Worksheet DSH
Date/Time Prepared:
5/29/2014 3:14 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	6.47	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	6.47	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.	6.47	31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 264012

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

Worksheet E
Part B
Date/Time Prepared:
5/29/2014 3:14 pm

		Title XVIII	Hospital	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)		5,098,000	2.00
3.00	PPS payments		6,427,085	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 chargebasis 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)		6,427,085	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,298,111	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)		5,128,974	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)		5,128,974	30.00
31.00	Primary payer payments		17,279	31.00
32.00	Subtotal (line 30 minus line 31)		5,111,695	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)		74,046	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		48,130	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		66,706	36.00
37.00	Subtotal (see instructions)		5,159,825	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENT		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)		5,159,825	40.00
40.01	Sequestration adjustment (see instructions)		77,913	40.01
41.00	Interim payments		5,032,735	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		49,177	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: 264012

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

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2014 3:14 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		5,267,174		5,032,735	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		5,267,174		5,032,735	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		138,493		49,177	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		5,405,667		5,081,912	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
				1.00	2.00		
8.00	Name of Contractor		0			8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 264012	Period: From 01/01/2013 To 12/31/2013	worksheet E-3 Part II Date/Time Prepared: 5/29/2014 3:14 pm
	Title XVIII	Hospital	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)	6,086,420	1.00
2.00	Net IPF PPS Outlier Payments	41,771	2.00
3.00	Net IPF PPS ECT Payments	32,751	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)	80.145205	9.00
10.00	Teaching Adjustment Factor $\{(1 + (line\ 8/line\ 9))\}$ 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)	6,160,942	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)	0	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)	6,160,942	16.00
17.00	Primary payer payments	112,503	17.00
18.00	Subtotal (line 16 less line 17).	6,048,439	18.00
19.00	Deductibles	508,335	19.00
20.00	Subtotal (line 18 minus line 19)	5,540,104	20.00
21.00	Coinsurance	190,617	21.00
22.00	Subtotal (line 20 minus line 21)	5,349,487	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	213,934	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	139,057	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	124,621	25.00
26.00	Subtotal (sum of lines 22 and 24)	5,488,544	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 ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	5,488,544	31.00
31.01	Sequestration adjustment (see instructions)	82,877	31.01
32.00	Interim payments	5,267,174	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	138,493	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	41,771	50.00
51.00	outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 264012

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

Worksheet E-3
Part VII
Date/Time Prepared:
5/29/2014 3:14 pm

		Title XIX		Hospital	Cost	
				Inpatient	Outpatient	
				1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES						
COMPUTATION OF NET COST OF COVERED SERVICES						
1.00	Inpatient hospital/SNF/NF services			2,488,006		1.00
2.00	Medical and other services				0	2.00
3.00	Organ acquisition (certified transplant centers only)			0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)			2,488,006	0	4.00
5.00	Inpatient primary payer payments			1,320,806		5.00
6.00	Outpatient primary payer payments				0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)			1,167,200	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES						
Reasonable Charges						
8.00	Routine service charges			4,856,419		8.00
9.00	Ancillary service charges			232,787	0	9.00
10.00	Organ acquisition charges, net of revenue			0		10.00
11.00	Incentive from target amount computation			0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)			5,089,206	0	12.00
CUSTOMARY CHARGES						
13.00	Amount actually collected from patients liable for payment for services on a charge basis			0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)			0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)			5,089,206	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			2,601,206	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			0	0	18.00
19.00	Interns and Residents (see instructions)			0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)			0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)			2,488,006	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.						
22.00	Other than outlier payments			0	0	22.00
23.00	Outlier payments			0	0	23.00
24.00	Program capital payments			0	0	24.00
25.00	Capital exception payments (see instructions)			0	0	25.00
26.00	Routine and Ancillary service other pass through costs			0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)			0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)			0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)			2,488,006	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT						
30.00	Excess of reasonable cost (from line 18)			0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			1,167,200	0	31.00
32.00	Deductibles			0	0	32.00
33.00	Coinurance			0	0	33.00
34.00	Allowable bad debts (see instructions)			0	0	34.00
35.00	Utilization review			0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)			1,167,200	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	0	37.00
38.00	Subtotal (line 36 ± line 37)			1,167,200	0	38.00
39.00	Direct graduate medical education payments (from wkst. E-4)			0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)			1,167,200	0	40.00
41.00	Interim payments			0	0	41.00
42.00	Balance due provider/program (line 40 minus 41)			1,167,200	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2			0	0	43.00

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

Provider CCN: 264012

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

Worksheet G

Date/Time Prepared:
5/29/2014 3:14 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	-324,927	0	0	0 1.00
2.00	Temporary investments	0	0	0	0 2.00
3.00	Notes receivable	0	0	0	0 3.00
4.00	Accounts receivable	10,787,795	0	0	0 4.00
5.00	Other receivable	1,206,170	0	0	0 5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,794,714	0	0	0 6.00
7.00	Inventory	424,407	0	0	0 7.00
8.00	Prepaid expenses	197,356	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)	8,496,087	0	0	0 11.00
FIXED ASSETS					
12.00	Land	0	0	0	0 12.00
13.00	Land improvements	0	0	0	0 13.00
14.00	Accumulated depreciation	0	0	0	0 14.00
15.00	Buildings	0	0	0	0 15.00
16.00	Accumulated depreciation	0	0	0	0 16.00
17.00	Leasehold improvements	1,245,745	0	0	0 17.00
18.00	Accumulated depreciation	-452,982	0	0	0 18.00
19.00	Fixed equipment	0	0	0	0 19.00
20.00	Accumulated depreciation	0	0	0	0 20.00
21.00	Automobiles and trucks	374,095	0	0	0 21.00
22.00	Accumulated depreciation	-338,470	0	0	0 22.00
23.00	Major movable equipment	3,981,307	0	0	0 23.00
24.00	Accumulated depreciation	-2,802,571	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)	2,007,124	0	0	0 30.00
OTHER ASSETS					
31.00	Investments	200,000	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	34,585	0	0	0 34.00
35.00	Total other assets (sum of lines 31-34)	234,585	0	0	0 35.00
36.00	Total assets (sum of lines 11, 30, and 35)	10,737,796	0	0	0 36.00
CURRENT LIABILITIES					
37.00	Accounts payable	926,421	0	0	0 37.00
38.00	Salaries, wages, and fees payable	623,406	0	0	0 38.00
39.00	Payroll taxes payable	237,620	0	0	0 39.00
40.00	Notes and loans payable (short term)	0	0	0	0 40.00
41.00	Deferred income	0	0	0	0 41.00
42.00	Accelerated payments	0	0	0	0 42.00
43.00	Due to other funds	-258,609	0	0	0 43.00
44.00	Other current liabilities	774,044	0	0	0 44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,302,882	0	0	0 45.00
LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0 46.00
47.00	Notes payable	0	0	0	0 47.00
48.00	Unsecured loans	2,100,000	0	0	0 48.00
49.00	Other long term liabilities	0	0	0	0 49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,100,000	0	0	0 50.00
51.00	Total liabilities (sum of lines 45 and 50)	4,402,882	0	0	0 51.00
CAPITAL ACCOUNTS					
52.00	General fund balance	6,334,914	0	0	0 52.00
53.00	Specific purpose fund	0	0	0	0 53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0 54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0 55.00
56.00	Governing body created - endowment fund balance	0	0	0	0 56.00
57.00	Plant fund balance - invested in plant	0	0	0	0 57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0 58.00
59.00	Total fund balances (sum of lines 52 thru 58)	6,334,914	0	0	0 59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	10,737,796	0	0	0 60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 264012

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

worksheet G-1

Date/Time Prepared:
5/29/2014 3:14 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		6,217,560			0	1.00
2.00	Net income (loss) (from wkst. G-3, line 29)		1,227,048				2.00
3.00	Total (sum of line 1 and line 2)		7,444,608			0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0			0	10.00
11.00	Subtotal (line 3 plus line 10)		7,444,608			0	11.00
12.00	Deductions (debit adjustments) (specify)						12.00
13.00	CHANGE IN PARTNERS CAPITAL	1,109,694					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)		1,109,694			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		6,334,914			0	19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00	CHANGE IN PARTNERS CAPITAL		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: 264012

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/29/2014 3:14 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	25,379,520		25,379,520	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	25,379,520		25,379,520	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,495,000		3,495,000	11.00
11.01	CHEMICAL DEPENDENCY/SAFE	0		0	11.01
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)	3,495,000		3,495,000	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	28,874,520		28,874,520	17.00
18.00	Ancillary services	5,214,158	0	5,214,158	18.00
19.00	Outpatient services	0	44,299,188	44,299,188	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	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	34,088,678	44,299,188	78,387,866	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		41,820,894		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)		41,820,894		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 264012

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

Worksheet G-3

Date/Time Prepared:
5/29/2014 3:14 pm

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	78,387,866	1.00
2.00	Less contractual allowances and discounts on patients' accounts	35,615,621	2.00
3.00	Net patient revenues (line 1 minus line 2)	42,772,245	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	41,820,894	4.00
5.00	Net income from service to patients (line 3 minus line 4)	951,351	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	23,773	6.00
7.00	Income from investments	9,449	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	81,608	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	845	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	150	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	12,753	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	SERVICE AGREEMENT	42,606	24.00
24.01	OTHER INCOME	102,913	24.01
24.02	LOSS ON SALE	1,600	24.02
24.03	BAD DEBT	0	24.03
25.00	Total other income (sum of lines 6-24)	275,697	25.00
26.00	Total (line 5 plus line 25)	1,227,048	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)	1,227,048	29.00