

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: 153028	Period: From 01/01/2013 To 12/31/2013	Worksheet S Parts I-III Date/Time Prepared: 5/29/2014 9:16 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/29/2014 Time: 9:16 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by REHABILITATION HOSPITAL OF INDIANA (153028) for the cost reporting period beginning 01/01/2013 and ending 12/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information
ECR: Date: 5/29/2014 Time: 9:16 am
IKH5gl LOuCqAoDk: HBuWuh: CStOyLO
CUq1r0rw83FrTXi BBpEhNgCi t4w84C
jAFS0FX: aF0zkF9I
PI: Date: 5/29/2014 Time: 9:16 am
PVGyKvp1cl 22uBi Hq4o: bCD1SGeJtO
4duZLOWAVKxrD. EOKr9i HN9DTb0b9Q
2bi i0cV4h5023MuH

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

Title

Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-151,428	11,261	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	-151,428	11,261	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

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

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

Title

Date

Cost Center Description	Title XVIII			HIT	Title XIX	
	Title V	Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-151,428	11,261	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
12.00 CMHC I	0		0		0	12.00
200.00 Total	0	-151,428	11,261	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 153028	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/27/2014 2:15 pm
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1.00	2.00	3.00	4.00	1.00
Hospital and Hospital Health Care Complex Address:				
1.00	Street: 4141 SHORE DRIVE	PO Box:		1.00
2.00	City: INDIANAPOLIS	State: IN	Zip Code: 46254	2.00
			County: MARION	

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
						V	XVIII	XIX	
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		

Hospital and Hospital-Based Component Identification:										
3.00	Hospital	REHABILITATION HOSPITAL OF INDIANA	153028	26900	5	01/07/1992	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

						From:	To:		
						1.00	2.00		

20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2013	12/31/2013	20.00
21.00	Type of Control (see instructions)	4		21.00

Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					N	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)									22.01
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	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	
24.00	0	0	0	0	0	0	24.00
25.00	1,481	1,240	0	0	63		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 153028	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/27/2014 2:15 pm		
		Urban/Rural S	Date of Geogr			
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0			35.00	
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	0			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.	0			38.00	
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N		39.00	
		V	XVII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	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.	Y			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N			57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
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/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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 153028

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

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

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

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		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	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y		75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			Y	N	0
				1.00		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		
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		
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					
				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		
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	95.00

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		V	XIX			
		1.00	2.00			
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column. Rural Providers	0.00	0.00	97.00		
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00		
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00		
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	
				1.00	2.00	3.00
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0	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:	146,779	0	0		
				1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N			118.02
DO NOT USE THIS LINE						
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N		N	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
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 153028		Period: From 01/01/2013 To 12/31/2013		Worksheet S-2 Part I Date/Time Prepared: 5/27/2014 2:15 pm	
		1.00		2.00			
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		15H059		140.00	
		1.00		2.00		3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: IU HEALTH	Contractor's Name: WPS		Contractor's Number: 08101			
142.00	Street: 340 W 10TH STREET	PO Box:					
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46202			
		1.00		2.00		3.00	
144.00	Are provider based physicians' costs included in Worksheet A?	N		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 1.00		Part B 2.00		Title V 3.00	
						Title XIX 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	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC						
161.10	CORF			N		N	
		1.00		2.00		3.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N		165.00			
		Name		County		State	
		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		2.00		3.00	
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)			0.00			
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.00			
		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: 153028	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/27/2014 2:15 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
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.	Y			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	Legal Oper.		
		1.00	2.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/09/2014	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
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 153028	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/27/2014 2:15 pm	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	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				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
					Y/N
					Date
					1.00
					2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				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.	RHONDA		UTTER	41.00
42.00	Enter the employer/company name of the cost report preparer.	IU HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-962-1093		RUTTER@IUHEALTH.ORG	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	05/09/2014	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.	MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 153028

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

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2014 2:15 pm

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	91	33,215	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)		91	33,215	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		91	33,215	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	99.00				0	25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		91				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 153028

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

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2014 2:15 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents			
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll		
	6.00	7.00	8.00	9.00	10.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	9,099	2,721	21,921			1.00
2.00	HMO and other (see instructions)	662	63				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)	9,099	2,721	21,921			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	9,099	2,721	21,921	3.00	301.12	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	0	0	0	0.00	0.00	25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				3.00	301.12	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 153028

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

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2014 2:15 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	622	140	1,330	1.00
2.00 HMO and other (see instructions)				42			2.00
3.00 HMO IPF Subprovider							3.00
4.00 HMO IRF Subprovider							4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0	622	140	1,330		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	0.00						25.00
25.10 CMHC - CORF	0.00						25.10
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: 153028

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

Worksheet A
Date/Time Prepared:
5/27/2014 2:15 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		1,074,576	1,074,576	0	1,074,576	1.00
2.00	00200		582,805	582,805	0	582,805	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	215,518	5,986,051	6,201,569	0	6,201,569	4.00
5.01	00591	2,309,987	1,313,430	3,623,417	-124,645	3,498,772	5.01
5.02	00590	699,302	320,039	1,019,341	0	1,019,341	5.02
7.00	00700	379,006	1,040,525	1,419,531	0	1,419,531	7.00
8.00	00800	0	104,549	104,549	0	104,549	8.00
9.00	00900	267,339	179,039	446,378	0	446,378	9.00
10.00	01000	61,820	973,321	1,035,141	-333,212	701,929	10.00
11.00	01100	0	0	0	333,212	333,212	11.00
13.00	01300	1,145,443	140,843	1,286,286	124,645	1,410,931	13.00
14.00	01400	69,036	51,829	120,865	0	120,865	14.00
15.00	01500	403,323	168,165	571,488	0	571,488	15.00
16.00	01600	675,134	1,455,142	2,130,276	0	2,130,276	16.00
17.00	01700	536,995	119,499	656,494	0	656,494	17.00
22.00	02200	0	227,256	227,256	0	227,256	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	6,496,102	1,393,411	7,889,513	0	7,889,513	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	0	50.00
54.00	05400	56,465	26,410	82,875	0	82,875	54.00
60.00	06000	0	464,266	464,266	0	464,266	60.00
65.00	06500	319,923	164,495	484,418	0	484,418	65.00
66.00	06600	1,766,429	283,478	2,049,907	161,918	2,211,825	66.00
66.01	06601	291,085	139,622	430,707	0	430,707	66.01
67.00	06700	1,518,675	150,892	1,669,567	229,674	1,899,241	67.00
68.00	06800	574,667	73,144	647,811	221,469	869,280	68.00
68.01	06801	169,432	27,450	196,882	0	196,882	68.01
68.02	06802	49,779	13,095	62,874	0	62,874	68.02
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	97,248	97,248	0	97,248	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	1,027,330	1,027,330	0	1,027,330	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03550	519,763	86,014	605,777	0	605,777	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	171,113	492,126	663,239	0	663,239	90.00
90.01	09001	0	0	0	0	0	90.01
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	0	0	0	0	0	99.00
99.10	09910	423,589	189,472	613,061	-613,061	0	99.10
SPECIAL PURPOSE COST CENTERS							
118.00		19,119,925	18,365,522	37,485,447	0	37,485,447	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	719,140	719,140	0	719,140	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	213,603	101,732	315,335	0	315,335	194.01
200.00		19,333,528	19,186,394	38,519,922	0	38,519,922	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 153028

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

Worksheet A
Date/Time Prepared:
5/27/2014 2:15 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	109,992	1,184,568	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	56,592	639,397	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	327,392	6,528,961	4.00
5.01	00591	ADMINISTRATIVE AND GENERAL	664,537	4,163,309	5.01
5.02	00590	OTHER A&G - NON FOUNDATION	-587,228	432,113	5.02
7.00	00700	OPERATION OF PLANT	179,391	1,598,922	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	104,549	8.00
9.00	00900	HOUSEKEEPING	33,556	479,934	9.00
10.00	01000	DIETARY	0	701,929	10.00
11.00	01100	CAFETERIA	-110,730	222,482	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,410,931	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-1,417	119,448	14.00
15.00	01500	PHARMACY	-3,693	567,795	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-852	2,129,424	16.00
17.00	01700	SOCIAL SERVICE	0	656,494	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	227,256	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	7,889,513	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	82,875	54.00
60.00	06000	LABORATORY	-174,411	289,855	60.00
65.00	06500	RESPIRATORY THERAPY	0	484,418	65.00
66.00	06600	PHYSICAL THERAPY	-7,465	2,204,360	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	-1,584	429,123	66.01
67.00	06700	OCCUPATIONAL THERAPY	-10,560	1,888,681	67.00
68.00	06800	SPEECH PATHOLOGY	-10,184	859,096	68.00
68.01	06801	VISION	0	196,882	68.01
68.02	06802	FAC RESOURCE	0	62,874	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	97,248	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,027,330	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03550	PSYCHOLOGY	-1,500	604,277	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-19,834	643,405	90.00
90.01	09001	SLEEP CENTER	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
99.00	09900	CMHC	0	0	99.00
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	442,002	37,927,449	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	719,140	192.00
194.00	07950	FOUNDATION	839,988	839,988	194.00
194.01	07951	PUBLIC RELATIONS	0	315,335	194.01
200.00		TOTAL (SUM OF LINES 118-199)	1,281,990	39,801,912	200.00

RECLASSIFICATIONS

Provider CCN: 153028

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

Worksheet A-6

Date/Time Prepared:
5/27/2014 2:15 pm

		Increases			
Cost Center		Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	19,900	313,312	1.00
	TOTALS		19,900	313,312	
B - NURSING ADMINISTRATION					
1.00	NURSING ADMINISTRATION	13.00	124,645	0	1.00
	TOTALS		124,645	0	
D - NCR (CORF)					
1.00	PHYSICAL THERAPY	66.00	111,876	50,042	1.00
2.00	OCCUPATIONAL THERAPY	67.00	158,691	70,983	2.00
3.00	SPEECH PATHOLOGY	68.00	153,022	68,447	3.00
	TOTALS		423,589	189,472	
500.00	Grand Total: Increases		568,134	502,784	500.00

RECLASSIFICATIONS

Provider CCN: 153028

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

Worksheet A-6

Date/Time Prepared:
5/27/2014 2:15 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA							
1.00	DIETARY	10.00	19,900	313,312	0		1.00
	TOTALS		19,900	313,312			
B - NURSING ADMINISTRATION							
1.00	ADMINISTRATIVE AND GENERAL	5.01	124,645	0	0		1.00
	TOTALS		124,645	0			
D - NCR (CORF)							
1.00	CORF	99.10	423,589	189,472	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		423,589	189,472			
500.00	Grand Total: Decreases		568,134	502,784			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 153028

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

Worksheet A-7
Part I
Date/Time Prepared:
5/27/2014 2:15 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,506,638	0	0	0	1.00
2.00	Land Improvements	290,246	9,835	0	9,835	2.00
3.00	Buildings and Fixtures	14,377,505	213,364	0	213,364	3.00
4.00	Building Improvements	95,017	0	0	0	4.00
5.00	Fixed Equipment	2,212,050	0	0	0	5.00
6.00	Movable Equipment	7,317,897	3,370,061	0	3,370,061	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	26,799,353	3,593,260	0	3,593,260	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	26,799,353	3,593,260	0	3,593,260	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,506,638	0			1.00
2.00	Land Improvements	300,081	0			2.00
3.00	Buildings and Fixtures	14,590,869	0			3.00
4.00	Building Improvements	95,017	0			4.00
5.00	Fixed Equipment	2,042,475	0			5.00
6.00	Movable Equipment	10,687,958	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	30,223,038	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	30,223,038	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 153028

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

Worksheet A-7
Part II
Date/Time Prepared:
5/27/2014 2:15 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	560,130	0	470,879	43,567	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	553,802	0	0	2,809	0	2.00
3.00	Total (sum of lines 1-2)	1,113,932	0	470,879	46,376	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	1,074,576				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	26,194	582,805				2.00
3.00	Total (sum of lines 1-2)	26,194	1,657,381				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 153028

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

Worksheet A-7
Part III
Date/Time Prepared:
5/27/2014 2:15 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	19,535,080	0	19,535,080	0.646364	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	10,687,958	0	10,687,958	0.353636	0	2.00
3.00	Total (sum of lines 1-2)	30,223,038	0	30,223,038	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	678,138	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	610,394	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,288,532	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	462,863	43,567	0	0	1,184,568	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,809	0	26,194	639,397	2.00
3.00	Total (sum of lines 1-2)	462,863	46,376	0	26,194	1,823,965	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 153028

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

Worksheet A-8

Date/Time Prepared:
5/27/2014 2:15 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center		Line #	Wkst. A-7 Ref.
			1.00	2.00	3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-8,016	CAP REL COSTS-BLDG & FIXT	1.00	11	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)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-25,315	OPERATION OF PLANT	7.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-30,065	ADMINISTRATIVE AND GENERAL	5.01	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	0			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	1,740,417			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-115,427	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	B	-1,417	CENTRAL SERVICES & SUPPLY	14.00	0	16.00
17.00 Sale of drugs to other than patients	B	-3,693	PHARMACY	15.00	0	17.00
18.00 Sale of medical records and abstracts	B	-852	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		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00 MISCELLANEOUS EMPLOYEE BENEFITS REV	B	-2,922	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00

Provider CCN: 153028

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

Worksheet A-8

Date/Time Prepared:
 5/27/2014 2:15 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
33.01 MISCELLANEOUS REVENUE	B	-447,903	ADMINISTRATIVE AND GENERAL	5.01	0	33.01
33.02 MISCELLANEOUS REVENUE	B	-587,228	OTHER A&G - NON FOUNDATION	5.02	0	33.02
33.03 MISCELLANEOUS PLANT OPS REVENUE	B	-20,000	OPERATION OF PLANT	7.00	0	33.03
33.04 MISCELLANEOUS PT REVENUE	B	-7,465	PHYSICAL THERAPY	66.00	0	33.04
33.05 MISCELLANEOUS PT-CARMEL REVENUE	B	-1,584	PHYSICAL THERAPY - CARMEL	66.01	0	33.05
33.06 MISCELLANEOUS OT REVENUE	B	-10,560	OCCUPATIONAL THERAPY	67.00	0	33.06
33.07 MISCELLANEOUS ST REVENUE	B	-10,184	SPEECH PATHOLOGY	68.00	0	33.07
33.08 MISCELLANEOUS PSYCHOLOGY REVENUE	B	-1,500	PSYCHOLOGY	76.00	0	33.08
33.09 MISCELLANEOUS CLINIC REVENUE	B	-19,834	CLINIC	90.00	0	33.09
33.10 RHI FOUNDATION	A	839,988	FOUNDATION	194.00	0	33.10
33.11 DONATIONS	A	-4,000	ADMINISTRATIVE AND GENERAL	5.01	0	33.11
33.12 ADVERTISING	A	-450	ADMINISTRATIVE AND GENERAL	5.01	0	33.12
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,281,990				50.00

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

Provider CCN: 153028

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

Worksheet A-8-1

Date/Time Prepared:
5/27/2014 2:15 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	ALLOCATION FROM HO REPORT	118,008	0
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	ALLOCATION FROM HO REPORT	56,592	0
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	ALLOCATION FROM HO REPORT	330,314	0
4.00	5.01	ADMINISTRATIVE AND GENERAL	ALLOCATION FROM HO REPORT	1,414,591	267,636
4.01	7.00	OPERATION OF PLANT	ALLOCATION FROM HO REPORT	224,706	0
4.02	9.00	HOUSEKEEPING	ALLOCATION FROM HO REPORT	33,556	0
4.03	11.00	CAFETERIA	ALLOCATION FROM HO REPORT	4,697	0
4.04	30.00	ADULTS & PEDIATRICS	ALLOCATION FROM HO REPORT	125,934	125,934
4.05	60.00	LABORATORY	ALLOCATION FROM HO REPORT	289,444	463,855
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,597,842	857,425

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

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

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

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

6.00	B	51.00	IU HEALTH	51.00	6.00
7.00	B	49.00	ST. VINCENT	49.00	7.00
8.00		0.00		0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 153028

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

Worksheet A-8-1

Date/Time Prepared:
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	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	118,008	9		1.00
2.00	56,592	9		2.00
3.00	330,314	0		3.00
4.00	1,146,955	0		4.00
4.01	224,706	0		4.01
4.02	33,556	0		4.02
4.03	4,697	0		4.03
4.04	0	0		4.04
4.05	-174,411	0		4.05
5.00	1,740,417			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	MGMT COMPANY		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 153028

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

Worksheet B
Part I
Date/Time Prepared:
5/27/2014 2:15 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	1,184,568	1,184,568			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	639,397		639,397		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	6,528,961	20,335	10,976	6,560,272	4.00
5.01 00591	ADMINISTRATIVE AND GENERAL	4,163,309	38,151	20,593	749,891	4,971,944 5.01
5.02 00590	OTHER A&G - NON FOUNDATION	432,113	8,223	4,438	239,963	684,737 5.02
7.00 00700	OPERATION OF PLANT	1,598,922	10,833	5,847	130,054	1,745,656 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	104,549	0	0	0	104,549 8.00
9.00 00900	HOUSEKEEPING	479,934	10,155	5,481	91,736	587,306 9.00
10.00 01000	DIETARY	701,929	42,106	22,728	14,385	781,148 10.00
11.00 01100	CAFETERIA	222,482	19,996	10,793	6,829	260,100 11.00
13.00 01300	NURSING ADMINISTRATION	1,410,931	8,275	4,467	435,826	1,859,499 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	119,448	10,350	5,587	23,689	159,074 14.00
15.00 01500	PHARMACY	567,795	5,116	2,762	138,399	714,072 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,129,424	13,652	7,369	231,670	2,382,115 16.00
17.00 01700	SOCIAL SERVICE	656,494	3,628	1,959	184,268	846,349 17.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	227,256	1,305	705	0	229,266 22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	7,889,513	522,986	282,292	2,229,113	10,923,904 30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	0	0 50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	82,875	6,852	3,699	19,376	112,802 54.00
60.00 06000	LABORATORY	289,855	3,929	2,121	0	295,905 60.00
65.00 06500	RESPIRATORY THERAPY	484,418	15,584	8,412	109,780	618,194 65.00
66.00 06600	PHYSICAL THERAPY	2,204,360	190,691	102,930	644,533	3,142,514 66.00
66.01 06601	PHYSICAL THERAPY - CARMEL	429,123	0	0	99,885	529,008 66.01
67.00 06700	OCCUPATIONAL THERAPY	1,888,681	144,643	78,074	575,581	2,686,979 67.00
68.00 06800	SPEECH PATHOLOGY	859,096	41,649	22,481	249,704	1,172,930 68.00
68.01 06801	VISION	196,882	0	0	58,140	255,022 68.01
68.02 06802	FAC RESOURCE	62,874	7,283	3,931	17,081	91,169 68.02
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	97,248	0	0	0	97,248 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,027,330	0	0	0	1,027,330 73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0 74.00
76.00 03550	PSYCHOLOGY	604,277	8,184	4,417	178,355	795,233 76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	643,405	38,478	20,769	58,717	761,369 90.00
90.01 09001	SLEEP CENTER	0	0	0	0	0 90.01
91.00 09100	EMERGENCY	0	0	0	0	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
99.00 09900	CMHC	0	0	0	0	0 99.00
99.10 09910	CORF	0	0	0	0	0 99.10
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	37,927,449	1,172,404	632,831	6,486,975	37,835,422 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	719,140	10,076	5,439	0	734,655 192.00
194.00 07950	FOUNDATION	839,988	2,088	1,127	0	843,203 194.00
194.01 07951	PUBLIC RELATIONS	315,335	0	0	73,297	388,632 194.01
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)	39,801,912	1,184,568	639,397	6,560,272	39,801,912 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 153028

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		ADMINISTRATIVE AND GENERAL	Subtotal	OTHER A&G - NON FOUNDATION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5.01	5A.01	5.02	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00591	ADMINISTRATIVE AND GENERAL	4,971,944				5.01
5.02	00590	OTHER A&G - NON FOUNDATION	97,746	782,483	782,483		5.02
7.00	00700	OPERATION OF PLANT	249,191	1,994,847	40,005	2,034,852	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	14,924	119,473	2,396	0	121,869
9.00	00900	HOUSEKEEPING	83,837	671,143	13,459	18,665	0
10.00	01000	DIETARY	111,508	892,656	17,901	77,396	0
11.00	01100	CAFETERIA	37,129	297,229	5,961	36,755	0
13.00	01300	NURSING ADMINISTRATION	265,442	2,124,941	42,614	15,211	0
14.00	01400	CENTRAL SERVICES & SUPPLY	22,708	181,782	3,645	19,025	0
15.00	01500	PHARMACY	101,933	816,005	16,364	9,405	0
16.00	01600	MEDICAL RECORDS & LIBRARY	340,045	2,722,160	54,590	25,095	0
17.00	01700	SOCIAL SERVICE	120,815	967,164	19,396	6,670	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	32,727	261,993	5,254	2,399	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,559,377	12,483,281	250,327	961,310	119,706
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,102	128,904	2,585	12,595	0
60.00	06000	LABORATORY	42,240	338,145	6,781	7,221	0
65.00	06500	RESPIRATORY THERAPY	88,247	706,441	14,167	28,646	0
66.00	06600	PHYSICAL THERAPY	448,591	3,591,105	72,016	350,514	102
66.01	06601	PHYSICAL THERAPY - CARMEL	75,515	604,523	12,123	0	1,778
67.00	06700	OCCUPATIONAL THERAPY	383,564	3,070,543	61,577	265,872	144
68.00	06800	SPEECH PATHOLOGY	167,435	1,340,365	26,880	76,556	139
68.01	06801	VISION	36,404	291,426	5,844	0	0
68.02	06802	FAC RESOURCE	13,014	104,183	2,089	13,387	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,882	111,130	2,229	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	146,650	1,173,980	23,543	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03550	PSYCHOLOGY	113,519	908,752	18,224	15,043	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	108,685	870,054	17,448	70,727	0
90.01	09001	SLEEP CENTER	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,691,230	37,554,708	737,418	2,012,492	121,869
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	104,871	839,526	16,836	18,521	0
194.00	07950	FOUNDATION	120,366	963,569	19,323	3,839	0
194.01	07951	PUBLIC RELATIONS	55,477	444,109	8,906	0	0
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	4,971,944	39,801,912	782,483	2,034,852	121,869

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 153028

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00591						5.01
5.02	00590						5.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	703,267					9.00
10.00	01000	26,997	1,014,950				10.00
11.00	01100	12,820	0	352,765			11.00
13.00	01300	5,306	0	22,505	2,210,577		13.00
14.00	01400	6,636	0	2,639	0	213,727	14.00
15.00	01500	3,280	0	6,127	71,189	0	15.00
16.00	01600	8,753	0	14,041	163,145	23	16.00
17.00	01700	2,326	0	13,288	0	260	17.00
22.00	02200	837	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	335,316	1,014,950	161,642	1,878,137	160,868	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	0	50.00
54.00	05400	4,393	0	1,425	16,558	2,420	54.00
60.00	06000	2,519	0	0	0	235	60.00
65.00	06500	9,992	0	7,018	81,548	21,074	65.00
66.00	06600	122,263	0	40,275	0	3,489	66.00
66.01	06601	0	0	6,680	0	2,192	66.01
67.00	06700	92,739	0	35,510	0	773	67.00
68.00	06800	26,704	0	15,396	0	1,195	68.00
68.01	06801	0	0	3,271	0	1,677	68.01
68.02	06802	4,670	0	1,669	0	0	68.02
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03550	5,247	0	9,378	0	10,157	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	24,670	0	4,934	0	9,361	90.00
90.01	09001	0	0	0	0	0	90.01
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	0	0	0	0	0	99.00
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
118.00		695,468	1,014,950	345,798	2,210,577	213,724	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	6,460	0	0	0	3	192.00
194.00	07950	1,339	0	2,599	0	0	194.00
194.01	07951	0	0	4,368	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		703,267	1,014,950	352,765	2,210,577	213,727	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 153028

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

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

Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	Subtotal	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00591						5.01
5.02	00590						5.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500	922,370					15.00
16.00	01600	0	2,987,807				16.00
17.00	01700	0	0	1,009,104			17.00
22.00	02200	0	0	0	270,483		22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	2,987,807	1,009,104	270,483	21,632,931	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	0	50.00
54.00	05400	0	0	0	0	168,880	54.00
60.00	06000	0	0	0	0	354,901	60.00
65.00	06500	0	0	0	0	868,886	65.00
66.00	06600	0	0	0	0	4,179,764	66.00
66.01	06601	0	0	0	0	627,296	66.01
67.00	06700	0	0	0	0	3,527,158	67.00
68.00	06800	0	0	0	0	1,487,235	68.00
68.01	06801	0	0	0	0	302,218	68.01
68.02	06802	0	0	0	0	125,998	68.02
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	113,359	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	922,370	0	0	0	2,119,893	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03550	0	0	0	0	966,801	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	997,194	90.00
90.01	09001	0	0	0	0	0	90.01
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	0	0	0	0	0	99.00
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
118.00		922,370	2,987,807	1,009,104	270,483	37,472,514	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	881,346	192.00
194.00	07950	0	0	0	0	990,669	194.00
194.01	07951	0	0	0	0	457,383	194.01
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		922,370	2,987,807	1,009,104	270,483	39,801,912	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 153028

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00591	ADMINISTRATIVE AND GENERAL		5.01
5.02	00590	OTHER A&G - NON FOUNDATION		5.02
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-270,483	21,362,448
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	168,880
60.00	06000	LABORATORY	0	354,901
65.00	06500	RESPIRATORY THERAPY	0	868,886
66.00	06600	PHYSICAL THERAPY	0	4,179,764
66.01	06601	PHYSICAL THERAPY - CARMEL	0	627,296
67.00	06700	OCCUPATIONAL THERAPY	0	3,527,158
68.00	06800	SPEECH PATHOLOGY	0	1,487,235
68.01	06801	VISION	0	302,218
68.02	06802	FAC RESOURCE	0	125,998
69.00	06900	ELECTROCARDIOLOGY	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	113,359
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,119,893
74.00	07400	RENAL DIALYSIS	0	0
76.00	03550	PSYCHOLOGY	0	966,801
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	997,194
90.01	09001	SLEEP CENTER	0	0
91.00	09100	EMERGENCY	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0
OTHER REIMBURSABLE COST CENTERS				
99.00	09900	CMHC	0	0
99.10	09910	CORF	0	0
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-270,483	37,202,031
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	881,346
194.00	07950	FOUNDATION	0	990,669
194.01	07951	PUBLIC RELATIONS	0	457,383
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	-270,483	39,531,429

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 153028	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 5/27/2014 2:15 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT			
		BLDG & FIXT	MVBLE EQUIP					
		0	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	20,335	10,976	31,311	31,311	4.00
5.01	00591	ADMINISTRATIVE AND GENERAL	0	38,151	20,593	58,744	3,580	5.01
5.02	00590	OTHER A&G - NON FOUNDATION	0	8,223	4,438	12,661	1,145	5.02
7.00	00700	OPERATION OF PLANT	0	10,833	5,847	16,680	621	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	10,155	5,481	15,636	438	9.00
10.00	01000	DIETARY	0	42,106	22,728	64,834	69	10.00
11.00	01100	CAFETERIA	0	19,996	10,793	30,789	33	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,275	4,467	12,742	2,080	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,350	5,587	15,937	113	14.00
15.00	01500	PHARMACY	0	5,116	2,762	7,878	661	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,652	7,369	21,021	1,106	16.00
17.00	01700	SOCIAL SERVICE	0	3,628	1,959	5,587	880	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	1,305	705	2,010	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	522,986	282,292	805,278	10,634	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,852	3,699	10,551	92	54.00
60.00	06000	LABORATORY	0	3,929	2,121	6,050	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	15,584	8,412	23,996	524	65.00
66.00	06600	PHYSICAL THERAPY	0	190,691	102,930	293,621	3,077	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0	0	477	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	144,643	78,074	222,717	2,748	67.00
68.00	06800	SPEECH PATHOLOGY	0	41,649	22,481	64,130	1,192	68.00
68.01	06801	VISION	0	0	0	0	278	68.01
68.02	06802	FAC RESOURCE	0	7,283	3,931	11,214	82	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHOLOGY	0	8,184	4,417	12,601	851	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	38,478	20,769	59,247	280	90.00
90.01	09001	SLEEP CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,172,404	632,831	1,805,235	30,961	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,076	5,439	15,515	0	192.00
194.00	07950	FOUNDATION	0	2,088	1,127	3,215	0	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	350	194.01
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	1,184,568	639,397	1,823,965	31,311	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 153028

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

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Cost Center Description		ADMINISTRATIVE AND GENERAL	OTHER A&G - NON FOUNDATION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.01	5.02	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00591	ADMINISTRATIVE AND GENERAL	62,324				5.01
5.02	00590	OTHER A&G - NON FOUNDATION	1,225	15,031			5.02
7.00	00700	OPERATION OF PLANT	3,123	768	21,192		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	187	46	0	233	8.00
9.00	00900	HOUSEKEEPING	1,051	258	194	0	17,577
10.00	01000	DIETARY	1,397	344	806	0	675
11.00	01100	CAFETERIA	465	114	383	0	320
13.00	01300	NURSING ADMINISTRATION	3,327	818	158	0	133
14.00	01400	CENTRAL SERVICES & SUPPLY	285	70	198	0	166
15.00	01500	PHARMACY	1,277	314	98	0	82
16.00	01600	MEDICAL RECORDS & LIBRARY	4,262	1,048	261	0	219
17.00	01700	SOCIAL SERVICE	1,514	372	69	0	58
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	410	101	25	0	21
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	19,558	4,815	10,014	230	8,380
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	202	50	131	0	110
60.00	06000	LABORATORY	529	130	75	0	63
65.00	06500	RESPIRATORY THERAPY	1,106	272	298	0	250
66.00	06600	PHYSICAL THERAPY	5,622	1,383	3,650	0	3,056
66.01	06601	PHYSICAL THERAPY - CARMEL	946	233	0	3	0
67.00	06700	OCCUPATIONAL THERAPY	4,807	1,182	2,769	0	2,318
68.00	06800	SPEECH PATHOLOGY	2,098	516	797	0	667
68.01	06801	VISION	456	112	0	0	0
68.02	06802	FAC RESOURCE	163	40	139	0	117
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	174	43	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,838	452	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03550	PSYCHOLOGY	1,423	350	157	0	131
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,362	335	737	0	617
90.01	09001	SLEEP CENTER	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	58,807	14,166	20,959	233	17,383
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,314	323	193	0	161
194.00	07950	FOUNDATION	1,508	371	40	0	33
194.01	07951	PUBLIC RELATIONS	695	171	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	62,324	15,031	21,192	233	17,577

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 153028		Period: From 01/01/2013 To 12/31/2013		Worksheet B Part II Date/Time Prepared: 5/27/2014 2:15 pm	
Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00591						5.01
5.02	00590						5.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	68,125					10.00
11.00	01100	0	32,104				11.00
13.00	01300	0	2,048	21,306			13.00
14.00	01400	0	240	0	17,009		14.00
15.00	01500	0	558	686	0	11,554	15.00
16.00	01600	0	1,278	1,572	2	0	16.00
17.00	01700	0	1,209	0	21	0	17.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	68,125	14,708	18,102	12,802	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	0	50.00
54.00	05400	0	130	160	193	0	54.00
60.00	06000	0	0	0	19	0	60.00
65.00	06500	0	639	786	1,677	0	65.00
66.00	06600	0	3,665	0	278	0	66.00
66.01	06601	0	608	0	174	0	66.01
67.00	06700	0	3,232	0	62	0	67.00
68.00	06800	0	1,401	0	95	0	68.00
68.01	06801	0	298	0	133	0	68.01
68.02	06802	0	152	0	0	0	68.02
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	11,554	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03550	0	854	0	808	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	449	0	745	0	90.00
90.01	09001	0	0	0	0	0	90.01
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	0	0	0	0	0	99.00
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
118.00		68,125	31,469	21,306	17,009	11,554	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	237	0	0	0	194.00
194.01	07951	0	398	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		68,125	32,104	21,306	17,009	11,554	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 153028

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

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Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
				SERVICES-OTHER PRGM COSTS		
		16.00	17.00	22.00	24.00	25.00
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00591	ADMINISTRATIVE AND GENERAL				5.01
5.02	00590	OTHER A&G - NON FOUNDATION				5.02
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30,769			16.00
17.00	01700	SOCIAL SERVICE	0	9,710		17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	2,567	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,769	9,710	1,013,125	0 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0 50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	11,619	0 54.00
60.00	06000	LABORATORY	0	0	6,866	0 60.00
65.00	06500	RESPIRATORY THERAPY	0	0	29,548	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	314,352	0 66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	2,441	0 66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	239,835	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	70,896	0 68.00
68.01	06801	VISION	0	0	1,277	0 68.01
68.02	06802	FAC RESOURCE	0	0	11,907	0 68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	217	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	13,844	0 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0 74.00
76.00	03550	PSYCHOLOGY	0	0	17,175	0 76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	63,772	0 90.00
90.01	09001	SLEEP CENTER	0	0	0	0 90.01
91.00	09100	EMERGENCY	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0 99.00
99.10	09910	CORF	0	0	0	0 99.10
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	30,769	9,710	0	1,796,874 0 118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	17,506	0 192.00
194.00	07950	FOUNDATION	0	0	5,404	0 194.00
194.01	07951	PUBLIC RELATIONS	0	0	1,614	0 194.01
200.00		Cross Foot Adjustments			2,567	0 200.00
201.00		Negative Cost Centers	0	0	0	0 201.00
202.00		TOTAL (sum lines 118-201)	30,769	9,710	2,567	1,823,965 0 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 153028	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 5/27/2014 2:15 pm
Cost Center Description		Total		
		26.00		
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00591	ADMINISTRATIVE AND GENERAL		5.01
5.02	00590	OTHER A&G - NON FOUNDATION		5.02
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	1,013,125	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,619	54.00
60.00	06000	LABORATORY	6,866	60.00
65.00	06500	RESPIRATORY THERAPY	29,548	65.00
66.00	06600	PHYSICAL THERAPY	314,352	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	2,441	66.01
67.00	06700	OCCUPATIONAL THERAPY	239,835	67.00
68.00	06800	SPEECH PATHOLOGY	70,896	68.00
68.01	06801	VISION	1,277	68.01
68.02	06802	FAC RESOURCE	11,907	68.02
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	217	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,844	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
76.00	03550	PSYCHOLOGY	17,175	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	63,772	90.00
90.01	09001	SLEEP CENTER	0	90.01
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS				
99.00	09900	CMHC	0	99.00
99.10	09910	CORF	0	99.10
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,796,874	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	17,506	192.00
194.00	07950	FOUNDATION	5,404	194.00
194.01	07951	PUBLIC RELATIONS	1,614	194.01
200.00		Cross Foot Adjustments	2,567	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118-201)	1,823,965	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 153028

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

Worksheet B-1
Date/Time Prepared:
5/27/2014 2:15 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	90,757				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		90,757			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,558	1,558	19,118,010		4.00
5.01 00591	ADMINISTRATIVE AND GENERAL	2,923	2,923	2,185,342	-4,971,944	34,829,968
5.02 00590	OTHER A&G - NON FOUNDATION	630	630	699,302	0	684,737
7.00 00700	OPERATION OF PLANT	830	830	379,006	0	1,745,656
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	104,549
9.00 00900	HOUSEKEEPING	778	778	267,339	0	587,306
10.00 01000	DIETARY	3,226	3,226	41,920	0	781,148
11.00 01100	CAFETERIA	1,532	1,532	19,900	0	260,100
13.00 01300	NURSING ADMINISTRATION	634	634	1,270,088	0	1,859,499
14.00 01400	CENTRAL SERVICES & SUPPLY	793	793	69,036	0	159,074
15.00 01500	PHARMACY	392	392	403,323	0	714,072
16.00 01600	MEDICAL RECORDS & LIBRARY	1,046	1,046	675,134	0	2,382,115
17.00 01700	SOCIAL SERVICE	278	278	536,995	0	846,349
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	100	100	0	0	229,266
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	40,069	40,069	6,496,102	0	10,923,904
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	525	525	56,465	0	112,802
60.00 06000	LABORATORY	301	301	0	0	295,905
65.00 06500	RESPIRATORY THERAPY	1,194	1,194	319,923	0	618,194
66.00 06600	PHYSICAL THERAPY	14,610	14,610	1,878,305	0	3,142,514
66.01 06601	PHYSICAL THERAPY - CARMEL	0	0	291,085	0	529,008
67.00 06700	OCCUPATIONAL THERAPY	11,082	11,082	1,677,366	0	2,686,979
68.00 06800	SPEECH PATHOLOGY	3,191	3,191	727,689	0	1,172,930
68.01 06801	VISION	0	0	169,432	0	255,022
68.02 06802	FAC RESOURCE	558	558	49,779	0	91,169
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	97,248
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,027,330
74.00 07400	RENAL DIALYSIS	0	0	0	0	0
76.00 03550	PSYCHOLOGY	627	627	519,763	0	795,233
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	2,948	2,948	171,113	0	761,369
90.01 09001	SLEEP CENTER	0	0	0	0	0
91.00 09100	EMERGENCY	0	0	0	0	0
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
99.00 09900	CMHC	0	0	0	0	0
99.10 09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	89,825	89,825	18,904,407	-4,971,944	32,863,478
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	772	772	0	0	734,655
194.00 07950	FOUNDATION	160	160	0	0	843,203
194.01 07951	PUBLIC RELATIONS	0	0	213,603	0	388,632
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	1,184,568	639,397	6,560,272		4,971,944
203.00	Unit cost multiplier (Wkst. B, Part I)	13.052084	7.045154	0.343146		0.142749
204.00	Cost to be allocated (per Wkst. B, Part II)			31,311		62,324
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001638		0.001789

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 153028

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

Worksheet B-1

Date/Time Prepared:
5/27/2014 2:15 pm

Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (HOURS PAID)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00591						5.01
5.02	00590						5.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	65,763					10.00
11.00	01100	0	502,529				11.00
13.00	01300	0	32,059	271,022			13.00
14.00	01400	0	3,759	0	244,002		14.00
15.00	01500	0	8,728	8,728	0	100	15.00
16.00	01600	0	20,002	20,002	26	0	16.00
17.00	01700	0	18,930	0	297	0	17.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	65,763	230,264	230,264	183,656	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	0	50.00
54.00	05400	0	2,030	2,030	2,763	0	54.00
60.00	06000	0	0	0	268	0	60.00
65.00	06500	0	9,998	9,998	24,059	0	65.00
66.00	06600	0	57,373	0	3,983	0	66.00
66.01	06601	0	9,516	0	2,503	0	66.01
67.00	06700	0	50,586	0	883	0	67.00
68.00	06800	0	21,932	0	1,364	0	68.00
68.01	06801	0	4,660	0	1,914	0	68.01
68.02	06802	0	2,377	0	0	0	68.02
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	100	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03550	0	13,360	0	11,596	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	7,029	0	10,687	0	90.00
90.01	09001	0	0	0	0	0	90.01
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	0	0	0	0	0	99.00
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
118.00		65,763	492,603	271,022	243,999	100	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	3	0	192.00
194.00	07950	0	3,703	0	0	0	194.00
194.01	07951	0	6,223	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		1,014,950	352,765	2,210,577	213,727	922,370	202.00
203.00		15.433450	0.701979	8.156449	0.875923	9,223.700000	203.00
204.00		68,125	32,104	21,306	17,009	11,554	204.00
205.00		1.035917	0.063885	0.078614	0.069708	115.540000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 153028

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

Worksheet B-1
Date/Time Prepared:
5/27/2014 2:15 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (PATIENT DAYS)	SOCIAL SERVICE (PATIENT DAYS)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	
		16.00	17.00	22.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.01	00591				5.01
5.02	00590				5.02
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600	21,921			16.00
17.00	01700	0	21,921		17.00
22.00	02200	0	0	100	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	21,921	21,921	100	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	0	0	0	50.00
54.00	05400	0	0	0	54.00
60.00	06000	0	0	0	60.00
65.00	06500	0	0	0	65.00
66.00	06600	0	0	0	66.00
66.01	06601	0	0	0	66.01
67.00	06700	0	0	0	67.00
68.00	06800	0	0	0	68.00
68.01	06801	0	0	0	68.01
68.02	06802	0	0	0	68.02
69.00	06900	0	0	0	69.00
71.00	07100	0	0	0	71.00
72.00	07200	0	0	0	72.00
73.00	07300	0	0	0	73.00
74.00	07400	0	0	0	74.00
76.00	03550	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	0	0	0	90.00
90.01	09001	0	0	0	90.01
91.00	09100	0	0	0	91.00
92.00	09200	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
99.00	09900	0	0	0	99.00
99.10	09910	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
118.00		21,921	21,921	100	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	0	0	0	190.00
192.00	19200	0	0	0	192.00
194.00	07950	0	0	0	194.00
194.01	07951	0	0	0	194.01
200.00					200.00
201.00					201.00
202.00		2,987,807	1,009,104	270,483	202.00
203.00		136.298846	46.033666	2,704.830000	203.00
204.00		30,769	9,710	2,567	204.00
205.00		1.403631	0.442954	25.670000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153028

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

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

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	21,362,448		21,362,448	0	21,362,448	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0		0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	168,880		168,880	0	168,880	54.00
60.00	06000 LABORATORY	354,901		354,901	0	354,901	60.00
65.00	06500 RESPIRATORY THERAPY	868,886	0	868,886	0	868,886	65.00
66.00	06600 PHYSICAL THERAPY	4,179,764	0	4,179,764	0	4,179,764	66.00
66.01	06601 PHYSICAL THERAPY - CARMEL	627,296	0	627,296	0	627,296	66.01
67.00	06700 OCCUPATIONAL THERAPY	3,527,158	0	3,527,158	0	3,527,158	67.00
68.00	06800 SPEECH PATHOLOGY	1,487,235	0	1,487,235	0	1,487,235	68.00
68.01	06801 VISION	302,218	0	302,218	0	302,218	68.01
68.02	06802 FAC RESOURCE	125,998	0	125,998	0	125,998	68.02
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	113,359		113,359	0	113,359	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,119,893		2,119,893	0	2,119,893	73.00
74.00	07400 RENAL DIALYSIS	0		0	0	0	74.00
76.00	03550 PSYCHOLOGY	966,801		966,801	0	966,801	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	997,194		997,194	0	997,194	90.00
90.01	09001 SLEEP CENTER	0		0	0	0	90.01
91.00	09100 EMERGENCY	0		0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900 CMHC	0		0		0	99.00
99.10	09910 CORF	0		0		0	99.10
200.00	Subtotal (see instructions)	37,202,031	0	37,202,031	0	37,202,031	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	37,202,031	0	37,202,031	0	37,202,031	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153028

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

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

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
		9.00	10.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	34,237,418		34,237,418		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	621,492	5,240	626,732	0.269461	54.00
60.00	06000	LABORATORY	1,678,681	367	1,679,048	0.211370	60.00
65.00	06500	RESPIRATORY THERAPY	2,014,408	1,464	2,015,872	0.431022	65.00
66.00	06600	PHYSICAL THERAPY	10,273,388	3,804,015	14,077,403	0.296913	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	1,376,511	1,376,511	0.455714	66.01
67.00	06700	OCCUPATIONAL THERAPY	10,316,160	2,177,011	12,493,171	0.282327	67.00
68.00	06800	SPEECH PATHOLOGY	5,362,007	1,297,479	6,659,486	0.223326	68.00
68.01	06801	VISION	203,501	329,773	533,274	0.566722	68.01
68.02	06802	FAC RESOURCE	0	60,217	60,217	2.092399	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	704,674	45,080	749,754	0.151195	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,557,299	1,424,508	7,981,807	0.265591	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	74.00
76.00	03550	PSYCHOLOGY	287,514	400,480	687,994	1.405246	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,795	2,835,383	2,837,178	0.351474	90.00
90.01	09001	SLEEP CENTER	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0		99.00
99.10	09910	CORF	0	0	0		99.10
200.00		Subtotal (see instructions)	72,258,337	13,757,528	86,015,865		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	72,258,337	13,757,528	86,015,865		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 153028	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/27/2014 2:15 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS		30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.000000	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.269461	54.00
60.00	06000 LABORATORY	0.211370	60.00
65.00	06500 RESPIRATORY THERAPY	0.431022	65.00
66.00	06600 PHYSICAL THERAPY	0.296913	66.00
66.01	06601 PHYSICAL THERAPY - CARMEL	0.455714	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.282327	67.00
68.00	06800 SPEECH PATHOLOGY	0.223326	68.00
68.01	06801 VISION	0.566722	68.01
68.02	06802 FAC RESOURCE	2.092399	68.02
69.00	06900 ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.151195	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.265591	73.00
74.00	07400 RENAL DIALYSIS	0.000000	74.00
76.00	03550 PSYCHOLOGY	1.405246	76.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.351474	90.00
90.01	09001 SLEEP CENTER	0.000000	90.01
91.00	09100 EMERGENCY	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS			
99.00	09900 CMHC		99.00
99.10	09910 CORF		99.10
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: 153028

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

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

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital		PPS
				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	21,362,448		21,362,448	0	21,362,448		30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0		0	0	0		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	168,880		168,880	0	168,880		54.00
60.00	06000 LABORATORY	354,901		354,901	0	354,901		60.00
65.00	06500 RESPIRATORY THERAPY	868,886	0	868,886	0	868,886		65.00
66.00	06600 PHYSICAL THERAPY	4,179,764	0	4,179,764	0	4,179,764		66.00
66.01	06601 PHYSICAL THERAPY - CARMEL	627,296	0	627,296	0	627,296		66.01
67.00	06700 OCCUPATIONAL THERAPY	3,527,158	0	3,527,158	0	3,527,158		67.00
68.00	06800 SPEECH PATHOLOGY	1,487,235	0	1,487,235	0	1,487,235		68.00
68.01	06801 VISION	302,218	0	302,218	0	302,218		68.01
68.02	06802 FAC RESOURCE	125,998	0	125,998	0	125,998		68.02
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	113,359		113,359	0	113,359		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,119,893		2,119,893	0	2,119,893		73.00
74.00	07400 RENAL DIALYSIS	0		0	0	0		74.00
76.00	03550 PSYCHOLOGY	966,801		966,801	0	966,801		76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000 CLINIC	997,194		997,194	0	997,194		90.00
90.01	09001 SLEEP CENTER	0		0	0	0		90.01
91.00	09100 EMERGENCY	0		0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS								
99.00	09900 CMHC	0		0		0		99.00
99.10	09910 CORF	0		0		0		99.10
200.00	Subtotal (see instructions)	37,202,031	0	37,202,031	0	37,202,031		200.00
201.00	Less Observation Beds	0		0		0		201.00
202.00	Total (see instructions)	37,202,031	0	37,202,031	0	37,202,031		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153028

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

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

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00				
		9.00	Hospital		PPS			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	34,237,418		34,237,418			30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	621,492	5,240	626,732	0.269461	0.000000	54.00
60.00	06000	LABORATORY	1,678,681	367	1,679,048	0.211370	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,014,408	1,464	2,015,872	0.431022	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	10,273,388	3,804,015	14,077,403	0.296913	0.000000	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	1,376,511	1,376,511	0.455714	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	10,316,160	2,177,011	12,493,171	0.282327	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	5,362,007	1,297,479	6,659,486	0.223326	0.000000	68.00
68.01	06801	VISION	203,501	329,773	533,274	0.566722	0.000000	68.01
68.02	06802	FAC RESOURCE	0	60,217	60,217	2.092399	0.000000	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	704,674	45,080	749,754	0.151195	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,557,299	1,424,508	7,981,807	0.265591	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
76.00	03550	PSYCHOLOGY	287,514	400,480	687,994	1.405246	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,795	2,835,383	2,837,178	0.351474	0.000000	90.00
90.01	09001	SLEEP CENTER	0	0	0	0.000000	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0	0	0			99.00
99.10	09910	CORF	0	0	0			99.10
200.00		Subtotal (see instructions)	72,258,337	13,757,528	86,015,865			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	72,258,337	13,757,528	86,015,865			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153028

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

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

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.269461			54.00
60.00	06000 LABORATORY	0.211370			60.00
65.00	06500 RESPIRATORY THERAPY	0.431022			65.00
66.00	06600 PHYSICAL THERAPY	0.296913			66.00
66.01	06601 PHYSICAL THERAPY - CARMEL	0.455714			66.01
67.00	06700 OCCUPATIONAL THERAPY	0.282327			67.00
68.00	06800 SPEECH PATHOLOGY	0.223326			68.00
68.01	06801 VISION	0.566722			68.01
68.02	06802 FAC RESOURCE	2.092399			68.02
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.151195			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.265591			73.00
74.00	07400 RENAL DIALYSIS	0.000000			74.00
76.00	03550 PSYCHOLOGY	1.405246			76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.351474			90.00
90.01	09001 SLEEP CENTER	0.000000			90.01
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
99.00	09900 CMHC				99.00
99.10	09910 CORF				99.10
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

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

Provider CCN: 153028

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

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

Cost Center Description		Title XIX			Hospital		PPS
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	168,880	11,619	157,261	0	0	54.00
60.00	06000 LABORATORY	354,901	6,866	348,035	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	868,886	29,548	839,338	0	0	65.00
66.00	06600 PHYSICAL THERAPY	4,179,764	314,352	3,865,412	0	0	66.00
66.01	06601 PHYSICAL THERAPY - CARMEL	627,296	2,441	624,855	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	3,527,158	239,835	3,287,323	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	1,487,235	70,896	1,416,339	0	0	68.00
68.01	06801 VISION	302,218	1,277	300,941	0	0	68.01
68.02	06802 FAC RESOURCE	125,998	11,907	114,091	0	0	68.02
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	113,359	217	113,142	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,119,893	13,844	2,106,049	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550 PSYCHOLOGY	966,801	17,175	949,626	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	997,194	63,772	933,422	0	0	90.00
90.01	09001 SLEEP CENTER	0	0	0	0	0	90.01
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900 CMHC	0	0	0	0	0	99.00
99.10	09910 CORF	0	0	0	0	0	99.10
200.00	Subtotal (sum of lines 50 thru 199)	15,839,583	783,749	15,055,834	0	0	200.00
201.00	Less Observation Beds	0	0	0	0	0	201.00
202.00	Total (line 200 minus line 201)	15,839,583	783,749	15,055,834	0	0	202.00

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

Provider CCN: 153028

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

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

Cost Center Description			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
Title XIX Hospital PPS						
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	168,880	626,732	0.269461	54.00
60.00	06000	LABORATORY	354,901	1,679,048	0.211370	60.00
65.00	06500	RESPIRATORY THERAPY	868,886	2,015,872	0.431022	65.00
66.00	06600	PHYSICAL THERAPY	4,179,764	14,077,403	0.296913	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	627,296	1,376,511	0.455714	66.01
67.00	06700	OCCUPATIONAL THERAPY	3,527,158	12,493,171	0.282327	67.00
68.00	06800	SPEECH PATHOLOGY	1,487,235	6,659,486	0.223326	68.00
68.01	06801	VISION	302,218	533,274	0.566722	68.01
68.02	06802	FAC RESOURCE	125,998	60,217	2.092399	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	113,359	749,754	0.151195	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,119,893	7,981,807	0.265591	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	74.00
76.00	03550	PSYCHOLOGY	966,801	687,994	1.405246	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	997,194	2,837,178	0.351474	90.00
90.01	09001	SLEEP CENTER	0	0	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0.000000	99.00
99.10	09910	CORF	0	0	0.000000	99.10
200.00		Subtotal (sum of lines 50 thru 199)	15,839,583	51,778,447		200.00
201.00		Less Observation Beds	0	0		201.00
202.00		Total (line 200 minus line 201)	15,839,583	51,778,447		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 153028		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part I Date/Time Prepared: 5/27/2014 2:15 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,013,125	0	1,013,125	21,921	46.22	
200.00	Total (Lines 30-199)	1,013,125		1,013,125	21,921	200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	9,099	420,556				
200.00	Total (Lines 30-199)	9,099	420,556				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 153028	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/27/2014 2:15 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0.000000	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	11,619	626,732	0.018539	306,020	5,673	54.00
60.00	06000 LABORATORY	6,866	1,679,048	0.004089	745,030	3,046	60.00
65.00	06500 RESPIRATORY THERAPY	29,548	2,015,872	0.014658	866,925	12,707	65.00
66.00	06600 PHYSICAL THERAPY	314,352	14,077,403	0.022330	4,267,175	95,286	66.00
66.01	06601 PHYSICAL THERAPY - CARMEL	2,441	1,376,511	0.001773	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	239,835	12,493,171	0.019197	4,319,212	82,916	67.00
68.00	06800 SPEECH PATHOLOGY	70,896	6,659,486	0.010646	1,975,379	21,030	68.00
68.01	06801 VISION	1,277	533,274	0.002395	0	0	68.01
68.02	06802 FAC RESOURCE	11,907	60,217	0.197735	0	0	68.02
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	217	749,754	0.000289	595,986	172	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	13,844	7,981,807	0.001734	2,753,721	4,775	73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.00	03550 PSYCHOLOGY	17,175	687,994	0.024964	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	63,772	2,837,178	0.022477	0	0	90.00
90.01	09001 SLEEP CENTER	0	0	0.000000	0	0	90.01
91.00	09100 EMERGENCY	0	0	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0	0	92.00
200.00	Total (lines 50-199)	783,749	51,778,447		15,829,448	225,605	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 153028		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part III Date/Time Prepared: 5/27/2014 2:15 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	0	30.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	21,921	0.00	9,099	0		30.00
200.00		Total (lines 30-199)	21,921		9,099	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 153028	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/27/2014 2:15 pm
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Cost Center Description		Title XVIII				Hospital	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601 PHYSICAL THERAPY - CARMEL	0	0	0	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801 VISION	0	0	0	0	0	68.01
68.02	06802 FAC RESOURCE	0	0	0	0	0	68.02
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550 PSYCHOLOGY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 SLEEP CENTER	0	0	0	0	0	90.01
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 153028	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/27/2014 2:15 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0.000000	0.000000	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	626,732	0.000000	0.000000	306,020	54.00
60.00	06000 LABORATORY	0	1,679,048	0.000000	0.000000	745,030	60.00
65.00	06500 RESPIRATORY THERAPY	0	2,015,872	0.000000	0.000000	866,925	65.00
66.00	06600 PHYSICAL THERAPY	0	14,077,403	0.000000	0.000000	4,267,175	66.00
66.01	06601 PHYSICAL THERAPY - CARMEL	0	1,376,511	0.000000	0.000000	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0	12,493,171	0.000000	0.000000	4,319,212	67.00
68.00	06800 SPEECH PATHOLOGY	0	6,659,486	0.000000	0.000000	1,975,379	68.00
68.01	06801 VISION	0	533,274	0.000000	0.000000	0	68.01
68.02	06802 FAC RESOURCE	0	60,217	0.000000	0.000000	0	68.02
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	749,754	0.000000	0.000000	595,986	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	7,981,807	0.000000	0.000000	2,753,721	73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
76.00	03550 PSYCHOLOGY	0	687,994	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	2,837,178	0.000000	0.000000	0	90.00
90.01	09001 SLEEP CENTER	0	0	0.000000	0.000000	0	90.01
91.00	09100 EMERGENCY	0	0	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	51,778,447			15,829,448	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 153028	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/27/2014 2:15 pm
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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)	
		11.00	12.00	13.00	
Title XVIII Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	3,536	0	54.00
60.00	06000 LABORATORY	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	665	0	65.00
66.00	06600 PHYSICAL THERAPY	0	190	0	66.00
66.01	06601 PHYSICAL THERAPY - CARMEL	0	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0	1,598	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
68.01	06801 VISION	0	0	0	68.01
68.02	06802 FAC RESOURCE	0	0	0	68.02
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	16,463	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,255,841	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
76.00	03550 PSYCHOLOGY	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	419,445	0	90.00
90.01	09001 SLEEP CENTER	0	0	0	90.01
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00	Total (lines 50-199)	0	1,697,738	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 153028	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 2:15 pm
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Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.269461	3,536	0	0	953	54.00
60.00	06000	LABORATORY	0.211370	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.431022	665	0	0	287	65.00
66.00	06600	PHYSICAL THERAPY	0.296913	190	0	0	56	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0.455714	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.282327	1,598	0	0	451	67.00
68.00	06800	SPEECH PATHOLOGY	0.223326	0	0	0	0	68.00
68.01	06801	VISION	0.566722	0	0	0	0	68.01
68.02	06802	FAC RESOURCE	2.092399	0	0	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.151195	16,463	0	0	2,489	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.265591	1,255,841	0	0	333,540	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03550	PSYCHOLOGY	1.405246	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.351474	419,445	0	0	147,424	90.00
90.01	09001	SLEEP CENTER	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Subtotal (see instructions)		1,697,738	0	0	485,200	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		1,697,738	0	0	485,200	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 153028	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 2:15 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
66.01	06601 PHYSICAL THERAPY - CARMEL	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
68.01	06801 VISION	0	0	68.01
68.02	06802 FAC RESOURCE	0	0	68.02
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03550 PSYCHOLOGY	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
90.01	09001 SLEEP CENTER	0	0	90.01
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Subtotal (see instructions)	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 153028		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part I Date/Time Prepared: 5/27/2014 2:15 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,013,125	0	1,013,125	21,921	46.22	
200.00	Total (Lines 30-199)	1,013,125		1,013,125	21,921	200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	2,721	125,765	30.00			
200.00	Total (Lines 30-199)	2,721	125,765	200.00			

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 153028

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

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

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Title XIX Hospital		Capital Costs (column 3 x column 4)	
					Inpatient Program Charges	PPS		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0.000000	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,619	626,732	0.018539	43,688	810	54.00
60.00	06000	LABORATORY	6,866	1,679,048	0.004089	155,961	638	60.00
65.00	06500	RESPIRATORY THERAPY	29,548	2,015,872	0.014658	114,428	1,677	65.00
66.00	06600	PHYSICAL THERAPY	314,352	14,077,403	0.022330	904,241	20,192	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	2,441	1,376,511	0.001773	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	239,835	12,493,171	0.019197	933,311	17,917	67.00
68.00	06800	SPEECH PATHOLOGY	70,896	6,659,486	0.010646	512,736	5,459	68.00
68.01	06801	VISION	1,277	533,274	0.002395	23,912	57	68.01
68.02	06802	FAC RESOURCE	11,907	60,217	0.197735	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	217	749,754	0.000289	88,964	26	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,844	7,981,807	0.001734	602,565	1,045	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.00	03550	PSYCHOLOGY	17,175	687,994	0.024964	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	63,772	2,837,178	0.022477	0	0	90.00
90.01	09001	SLEEP CENTER	0	0	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0	0	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0	0	92.00
200.00		Total (lines 50-199)	783,749	51,778,447		3,379,806	47,821	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 153028		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part III Date/Time Prepared: 5/27/2014 2:15 pm	
Cost Center Description			Title XIX		Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	21,921	0.00	2,721	0		30.00
200.00		Total (lines 30-199)	21,921		2,721	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153028

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

Worksheet D
Part IV
Date/Time Prepared:
5/27/2014 2:15 pm

Cost Center Description		Title XIX				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
68.01	06801	VISION	0	0	0	0	0	0	68.01
68.02	06802	FAC RESOURCE	0	0	0	0	0	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
76.00	03550	PSYCHOLOGY	0	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	09001	SLEEP CENTER	0	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 153028	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/27/2014 2:15 pm
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Cost Center Description		Title XIX			Hospital		Inpatient Program Charges	
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0.000000	0.000000	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	626,732	0.000000	0.000000	43,688	54.00
60.00	06000	LABORATORY	0	1,679,048	0.000000	0.000000	155,961	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,015,872	0.000000	0.000000	114,428	65.00
66.00	06600	PHYSICAL THERAPY	0	14,077,403	0.000000	0.000000	904,241	66.00
66.01	06601	PHYSICAL THERAPY - CARMEL	0	1,376,511	0.000000	0.000000	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	12,493,171	0.000000	0.000000	933,311	67.00
68.00	06800	SPEECH PATHOLOGY	0	6,659,486	0.000000	0.000000	512,736	68.00
68.01	06801	VISION	0	533,274	0.000000	0.000000	23,912	68.01
68.02	06802	FAC RESOURCE	0	60,217	0.000000	0.000000	0	68.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	749,754	0.000000	0.000000	88,964	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,981,807	0.000000	0.000000	602,565	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
76.00	03550	PSYCHOLOGY	0	687,994	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	2,837,178	0.000000	0.000000	0	90.00
90.01	09001	SLEEP CENTER	0	0	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	0	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	51,778,447			3,379,806	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153028

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

Worksheet D
Part IV
Date/Time Prepared:
5/27/2014 2:15 pm

Cost Center Description		Title XIX			Hospital	PPS
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000 LABORATORY	0	0	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
66.01	06601 PHYSICAL THERAPY - CARMEL	0	0	0		66.01
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
68.01	06801 VISION	0	0	0		68.01
68.02	06802 FAC RESOURCE	0	0	0		68.02
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
76.00	03550 PSYCHOLOGY	0	0	0		76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
90.01	09001 SLEEP CENTER	0	0	0		90.01
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 153028	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 2:15 pm
	Title XIX	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, 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							
50.00 05000 OPERATING ROOM	0.000000	0	0	0	0	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.269461	0	0	0	0	0	54.00
60.00 06000 LABORATORY	0.211370	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.431022	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.296913	0	165,585	0	0	0	66.00
66.01 06601 PHYSICAL THERAPY - CARMEL	0.455714	0	16,692	0	0	0	66.01
67.00 06700 OCCUPATIONAL THERAPY	0.282327	0	134,510	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.223326	0	83,836	0	0	0	68.00
68.01 06801 VISION	0.566722	0	30,030	0	0	0	68.01
68.02 06802 FAC RESOURCE	2.092399	0	0	0	0	0	68.02
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.151195	0	4,430	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.265591	0	128,047	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
76.00 03550 PSYCHOLOGY	1.405246	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0.351474	0	281,766	0	0	0	90.00
90.01 09001 SLEEP CENTER	0.000000	0	0	0	0	0	90.01
91.00 09100 EMERGENCY	0.000000	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	0	92.00
200.00 Subtotal (see instructions)		0	844,896	0	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	844,896	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 153028	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 2:15 pm
		Title XIX	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	49,164	0	66.00
66.01	06601 PHYSICAL THERAPY - CARMEL	7,607	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	37,976	0	67.00
68.00	06800 SPEECH PATHOLOGY	18,723	0	68.00
68.01	06801 VISION	17,019	0	68.01
68.02	06802 FAC RESOURCE	0	0	68.02
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	670	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	34,008	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03550 PSYCHOLOGY	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	99,033	0	90.00
90.01	09001 SLEEP CENTER	0	0	90.01
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Subtotal (see instructions)	264,200	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	264,200	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 153028	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/27/2014 2:15 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		21,921	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		21,921	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		21,921	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)		9,099	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)		21,362,448	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)		21,362,448	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)		21,362,448	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)		974.52	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		8,867,157	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)		8,867,157	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 153028	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/27/2014 2:15 pm
Title XVIII			Hospital		PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					4,362,638 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					13,229,795 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)					420,556 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					225,605 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					646,161 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					12,583,634 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: 153028		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/27/2014 2:15 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,013,125	21,362,448	0.047426	0	0	90.00
91.00	Nursing School cost	0	21,362,448	0.000000	0	0	91.00
92.00	Allied health cost	0	21,362,448	0.000000	0	0	92.00
93.00	All other Medical Education	0	21,362,448	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 153028	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/27/2014 2:15 pm
Cost Center Description		Title XIX	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		21,921	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		21,921	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		21,921	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,721	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)		21,362,448	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)		21,362,448	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)		21,362,448	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)		974.52	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,651,669	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)		2,651,669	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 153028	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/27/2014 2:15 pm
Cost Center Description			Title XIX	Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
Cost Center Description					
					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				927,583 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				3,579,252 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)				125,765 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				47,821 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				173,586 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				3,405,666 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: 153028		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/27/2014 2:15 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,013,125	21,362,448	0.047426	0	0	90.00
91.00	Nursing School cost	0	21,362,448	0.000000	0	0	91.00
92.00	Allied health cost	0	21,362,448	0.000000	0	0	92.00
93.00	All other Medical Education	0	21,362,448	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 153028	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/27/2014 2:15 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		13,734,155		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.269461	306,020	82,460	54.00
60.00	06000 LABORATORY	0.211370	745,030	157,477	60.00
65.00	06500 RESPIRATORY THERAPY	0.431022	866,925	373,664	65.00
66.00	06600 PHYSICAL THERAPY	0.296913	4,267,175	1,266,980	66.00
66.01	06601 PHYSICAL THERAPY - CARMEL	0.455714	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.282327	4,319,212	1,219,430	67.00
68.00	06800 SPEECH PATHOLOGY	0.223326	1,975,379	441,153	68.00
68.01	06801 VISION	0.566722	0	0	68.01
68.02	06802 FAC RESOURCE	2.092399	0	0	68.02
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.151195	595,986	90,110	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.265591	2,753,721	731,364	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03550 PSYCHOLOGY	1.405246	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.351474	0	0	90.00
90.01	09001 SLEEP CENTER	0.000000	0	0	90.01
91.00	09100 EMERGENCY	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		15,829,448	4,362,638	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)		15,829,448		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 153028	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/27/2014 2:15 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		3,142,725		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.269461	43,688	11,772	54.00
60.00	06000 LABORATORY	0.211370	155,961	32,965	60.00
65.00	06500 RESPIRATORY THERAPY	0.431022	114,428	49,321	65.00
66.00	06600 PHYSICAL THERAPY	0.296913	904,241	268,481	66.00
66.01	06601 PHYSICAL THERAPY - CARMEL	0.455714	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.282327	933,311	263,499	67.00
68.00	06800 SPEECH PATHOLOGY	0.223326	512,736	114,507	68.00
68.01	06801 VISION	0.566722	23,912	13,551	68.01
68.02	06802 FAC RESOURCE	2.092399	0	0	68.02
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.151195	88,964	13,451	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.265591	602,565	160,036	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03550 PSYCHOLOGY	1.405246	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.351474	0	0	90.00
90.01	09001 SLEEP CENTER	0.000000	0	0	90.01
91.00	09100 EMERGENCY	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		3,379,806	927,583	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		3,379,806		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 153028	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/27/2014 2:15 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)			485,200 2.00
3.00	PPS payments			467,277 3.00
4.00	Outlier payment (see instructions)			1,419 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.866 5.00
6.00	Line 2 times line 5			420,183 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			0 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			0 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			468,696 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)			95,910 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)			372,786 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			3,894 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)			376,680 30.00
31.00	Primary payer payments			13 31.00
32.00	Subtotal (line 30 minus line 31)			376,667 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)			11,920 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			7,748 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			11,920 36.00
37.00	Subtotal (see instructions)			384,415 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			384,415 40.00
40.01	Sequestration adjustment (see instructions)			5,805 40.01
41.00	Interim payments			367,349 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			11,261 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 153028

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

Worksheet E-1
Part I
Date/Time Prepared:
5/27/2014 2:15 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		11,962,977		367,349	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)		11,962,977		367,349	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		11,261	6.01	
6.02	SETTLEMENT TO PROGRAM		151,428		0	6.02	
7.00	Total Medicare program liability (see instructions)		11,811,549		378,610	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 153028	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part III Date/Time Prepared: 5/27/2014 2:15 pm
		Title XVIII	Hospital	PPS
		Prior to 10/01	On/After 10/01	
		1.00	1.01	
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)	8,012,787	3,090,216	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0373		2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	582,530	152,966	3.00
4.00	Outlier Payments	289,110		4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.34		5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00		5.01
6.00	New Teaching program adjustment. (see instructions)	0.00		6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program". (see inst.)	2.92		7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program". (see inst.)	0.00		8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.34		9.00
10.00	Average Daily Census (see instructions)	60.057534		10.00
11.00	Teaching Adjustment Factor (see instructions)	0.003889	0.005754	11.00
12.00	Teaching Adjustment (see instructions)	31,162	17,781	12.00
13.00	Total PPS Payment (see instructions)	12,176,552		13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0		14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			15.00
16.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0		16.00
17.00	Subtotal (see instructions)	12,176,552		17.00
18.00	Primary payer payments	0		18.00
19.00	Subtotal (line 17 less line 18).	12,176,552		19.00
20.00	Deductibles	80,372		20.00
21.00	Subtotal (line 19 minus line 20)	12,096,180		21.00
22.00	Coinsurance	218,737		22.00
23.00	Subtotal (line 21 minus line 22)	11,877,443		23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	13,876		24.00
25.00	Adjusted reimbursable bad debts (see instructions)	9,019		25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	13,876		26.00
27.00	Subtotal (sum of lines 23 and 25)	11,886,462		27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	106,176		28.00
29.00	Other pass through costs (see instructions)	0		29.00
30.00	Outlier payments reconciliation	0		30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		31.00
31.99	Recovery of Accelerated Depreciation	0		31.99
32.00	Total amount payable to the provider (see instructions)	11,992,638		32.00
32.01	Sequestration adjustment (see instructions)	181,089		32.01
33.00	Interim payments	11,962,977		33.00
34.00	Tentative settlement (for contractor use only)	0		34.00
35.00	Balance due provider/program line 32 minus lines 32.01, 33 and 34	-151,428		35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0		36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4	289,110		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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 153028	Period: From 01/01/2013 To 12/31/2013	Worksheet E-4 Date/Time Prepared: 5/27/2014 2:15 pm	
		Title XVII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			2.92	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			2.92	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			2.92	6.00
7.00	Enter the lesser of line 5 or line 6			2.92	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	2.92	0.00	2.92	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	2.92	0.00	2.92	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
11.00	Total weighted FTE count	2.92	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	3.49	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	3.05	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	3.15	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
17.00	Adjusted rolling average FTE count	3.15	0.00		17.00
18.00	Per resident amount	79,233.43	79,233.43		18.00
19.00	Approved amount for resident costs	249,585	0	249,585	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			249,585	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	9,099	662		26.00
27.00	Total Inpatient Days (see instructions)	21,921	21,921		27.00
28.00	Ratio of inpatient days to total inpatient days	0.415081	0.030199		28.00
29.00	Program direct GME amount	103,598	7,537		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		1,065		30.00
31.00	Net Program direct GME amount			110,070	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 153028	Period: From 01/01/2013 To 12/31/2013	Worksheet E-4 Date/Time Prepared: 5/27/2014 2:15 pm
		Title XVIII	Hospital	PPS
				1.00
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Worksheet C, Part I, column 8, sum of lines 74 and 94)		0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		13,229,795	37.00
38.00	Organ acquisition costs (Worksheet D-4, Part III, column 1, line 69)		0	38.00
39.00	Cost of teaching physicians (Worksheet D-5, Part II, column 3, line 20)		0	39.00
40.00	Primary payer payments (see instructions)		0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		13,229,795	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		485,200	42.00
43.00	Primary payer payments (see instructions)		13	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		485,187	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		13,714,982	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.964624	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.035376	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		110,070	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (Title XVIII only) (see instructions)		106,176	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		3,894	50.00

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

Provider CCN: 153028

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

Worksheet G

Date/Time Prepared:
5/27/2014 2:15 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	7,324,117	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	14,698,407	0	0	0	4.00
5.00	Other receivable	752,013	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,787,832	0	0	0	6.00
7.00	Inventory	201,614	0	0	0	7.00
8.00	Prepaid expenses	540,541	0	0	0	8.00
9.00	Other current assets	676,427	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)	15,405,287	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,506,638	0	0	0	12.00
13.00	Land improvements	300,081	0	0	0	13.00
14.00	Accumulated depreciation	-164,517	0	0	0	14.00
15.00	Buildings	14,590,869	0	0	0	15.00
16.00	Accumulated depreciation	-10,089,193	0	0	0	16.00
17.00	Leasehold improvements	95,017	0	0	0	17.00
18.00	Accumulated depreciation	-74,392	0	0	0	18.00
19.00	Fixed equipment	2,042,475	0	0	0	19.00
20.00	Accumulated depreciation	-1,717,771	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	10,582,126	0	0	0	23.00
24.00	Accumulated depreciation	-6,241,754	0	0	0	24.00
25.00	Minor equipment depreciable	105,832	0	0	0	25.00
26.00	Accumulated depreciation	-105,832	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)	11,829,579	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	3,002,916	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	924,006	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,926,922	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	31,161,788	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,583,744	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,342,836	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	593,501	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	742,157	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,262,238	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	18,036,020	0	0	0	46.00
47.00	Notes payable	780,605	0	0	0	47.00
48.00	Unsecured loans	0	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)	18,816,625	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	25,078,863	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	6,082,925				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	6,082,925	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	31,161,788	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 153028

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

Worksheet G-1

Date/Time Prepared:
5/27/2014 2:15 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		4,419,466		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		1,663,453			2.00
3.00	Total (sum of line 1 and line 2)		6,082,919		0	3.00
4.00	ROUNDING	6		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		6		0	10.00
11.00	Subtotal (line 3 plus line 10)		6,082,925		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		6,082,925		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	ROUNDING		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 153028

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

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

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	34,237,418		34,237,418	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)	34,237,418		34,237,418	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	34,237,418		34,237,418	17.00
18.00	Ancillary services	38,026,919	134,825	38,161,744	18.00
19.00	Outpatient services	0	13,751,528	13,751,528	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		0	0	24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER	1,526	0	1,526	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	72,265,863	13,886,353	86,152,216	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		38,519,922		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)		38,519,922		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 153028

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

Worksheet G-3

Date/Time Prepared:
5/27/2014 2:15 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	86,152,216	1.00
2.00	Less contractual allowances and discounts on patients' accounts	47,721,599	2.00
3.00	Net patient revenues (line 1 minus line 2)	38,430,617	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	38,519,922	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-89,305	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER MISCELLANEOUS INCOME	1,752,758	24.00
25.00	Total other income (sum of lines 6-24)	1,752,758	25.00
26.00	Total (line 5 plus line 25)	1,663,453	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)	1,663,453	29.00