

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: 150059	Period: From 01/01/2013 To 12/31/2013	Worksheet S Parts I-III Date/Time Prepared: 5/23/2014 9:51 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: 5/23/2014 Time: 9:51 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 RIVERVIEW HOSPITAL ( 150059 ) for the cost reporting period beginning 01/01/2013 and ending 12/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) \_\_\_\_\_  
Officer or Administrator of Provider(s)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	-162,137	87,864	-48,423	222,961	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	93,112	0	0	11,169	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
7.00 SKILLED NURSING FACILITY	0	-442	0	0	0	7.00
200.00 Total	0	-69,467	87,864	-48,423	234,130	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 150059		Period: From 01/01/2013 To 12/31/2013		Worksheet S-2 Part I Date/Time Prepared: 5/23/2014 8:25 am			
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 395 WESTFIELD ROAD			PO Box:						1.00	
2.00	City: NOBLESVILLE			State: IN		Zip Code: 46060-		County: HAMILTON		2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		RIVERVIEW HOSPITAL	150059	26900	1	07/07/1966	N	P	O	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF		RIVERVIEW HOSPITAL REHAB	15T059	26900	5	01/01/1994	N	P	O	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		RIVERVIEW HOSPITAL SNF	155669	26900		10/26/1999	N	P	N	9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2013	12/31/2013		20.00	
21.00	Type of Control (see instructions)						9		21.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						Y	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)									22.01	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3	N		23.00	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days		
				1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			884	315	0	0	1,181	0	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.			173	0	0	0	40		25.00	
							Urban/Rural S	Date of Geogr			
							1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.							1		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.							1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							0		35.00	

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

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

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
<b>Inpatient Psychiatric Facility PPS</b>							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			N		0	76.00
					1.00		
<b>Long Term Care Hospital PPS</b>							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N	80.00
<b>TEFRA Providers</b>							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00
					V	XIX	
					1.00	2.00	
<b>Title V and XIX Services</b>							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N		Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.				0.00		97.00
<b>Rural Providers</b>							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			N			106.00

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		V	XIX		
		1.00	2.00		
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
		1.00	2.00	3.00	
<b>Miscellaneous Cost Reporting Information</b>					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2		
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	558,554	374,002	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		
119.00	DO NOT USE THIS LINE				
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N		N
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		
<b>Transplant Center Information</b>					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				
<b>All Providers</b>					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y		

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1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?					Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.					Y	145.00
						1.00	
						2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					N	146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N	149.00
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
						1.00	
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					1.00	169.00
						Beginni ng	Endi ng
						1.00	2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					01/01/2013	03/31/2013

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150059	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/23/2014 8:25 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			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	03/24/2014	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	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.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N	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	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/11/2014	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: 150059	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/23/2014 8:25 am	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
					1.00
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				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
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				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
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				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
<b>Home Office Costs</b>					
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
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MI CHAEL	ALESSANDRI NI		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.713.7959	MALESSANDRI NI@BLUEANDCO.COM		43.00

		Part B	
		Date	
		4.00	
<b>PS&amp;R Data</b>			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	05/11/2014	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	
<b>Cost Report Preparer Contact Information</b>			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150059

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/23/2014 8:25 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	90	32,850	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)		90	32,850	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	15	5,475	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		105	38,325	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	24	8,760		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	25	9,125		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		154				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: 150059

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/23/2014 8:25 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	5,035	884	13,049			1.00
2.00 HMO and other (see instructions)	1,183	1,342				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	143	40				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	5,035	884	13,049			7.00
8.00 INTENSIVE CARE UNIT	1,983	0	3,109			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		0	0			13.00
14.00 Total (see instructions)	7,018	884	16,158	0.00	1,079.73	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	4,041	173	6,108	0.00	27.73	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	3,605	0	5,234	0.00	0.00	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	1,107.46	27.00
28.00 Observation Bed Days		93	2,103			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	154	230			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: 150059

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/23/2014 8:25 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,577	165	3,827	1.00
2.00 HMO and other (see instructions)			290			2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,577	165	3,827	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	338	12	493	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150059

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/23/2014 8:25 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col .2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	64,334,136	2,772,082	67,106,218	2,303,511.00	29.13
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		23,309,077	58,562	23,367,639	620,454.00	37.66
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract labor (see instructions)		106,995	0	106,995	401.25	266.65
12.00	Contract management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		321,215	0	321,215	1,918.00	167.47
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		9,241,834	0	9,241,834		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		3,289,847	0	3,289,847		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FOHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits Department	4.00	579,102	0	579,102	18,271.00	31.70
27.00	Administrative & General	5.00	7,456,857	0	7,456,857	300,481.00	24.82
28.00	Administrative & General under contract (see inst.)		632,004	0	632,004	5,593.00	113.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	1,447,174	0	1,447,174	68,325.00	21.18
31.00	Laundry & Linen Service	8.00	40,678	0	40,678	2,313.00	17.59
32.00	Housekeeping	9.00	821,774	0	821,774	67,387.00	12.19
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	891,506	-652,467	239,039	19,971.00	11.97
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	593,905	593,905	49,620.00	11.97
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	712,398	0	712,398	17,449.00	40.83
39.00	Central Services and Supply	14.00	484,441	175,190	659,631	31,230.00	21.12
40.00	Pharmacy	15.00	1,872,213	0	1,872,213	49,174.00	38.07
41.00	Medical Records & Medical Records Library	16.00	567,542	0	567,542	31,542.00	17.99

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 150059		Period: From 01/01/2013 To 12/31/2013		Worksheet S-3 Part II Date/Time Prepared: 5/23/2014 8:25 am		
	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
42.00	Soci al Servi ce	17.00	306,198	0	306,198	10,569.00	28.97	42.00
43.00	Other General Servi ce	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150059

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/23/2014 8:25 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	64,966,140	2,772,082	67,738,222	2,309,104.00	29.34	1.00
2.00	Excluded area salaries (see instructions)	23,309,077	58,562	23,367,639	620,454.00	37.66	2.00
3.00	Subtotal salaries (line 1 minus line 2)	41,657,063	2,713,520	44,370,583	1,688,650.00	26.28	3.00
4.00	Subtotal other wages & related costs (see inst.)	428,210	0	428,210	2,319.25	184.63	4.00
5.00	Subtotal wage-related costs (see inst.)	9,241,834	0	9,241,834	0.00	20.83	5.00
6.00	Total (sum of lines 3 thru 5)	51,327,107	2,713,520	54,040,627	1,690,969.25	31.96	6.00
7.00	Total overhead cost (see instructions)	15,811,887	116,628	15,928,515	671,925.00	23.71	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150059	Period: From 01/01/2013 To 12/31/2013	Worksheet S-3 Part IV Date/Time Prepared: 5/23/2014 8:25 am
			Amount Reported	
			1.00	
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions		468,846	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration Fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)		6,682,590	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		208,110	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		31,440	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		186,972	14.00
15.00	'Workers' Compensation Insurance		163,242	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
<b>TAXES</b>				
17.00	FICA-Employers Portion Only		4,629,636	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		90,479	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		49,450	23.00
24.00	<b>Total Wage Related cost (Sum of lines 1 -23)</b>		<b>12,510,765</b>	<b>24.00</b>
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150059

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

Worksheet S-3  
Part V  
Date/Time Prepared:  
5/23/2014 8:25 am

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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 150059

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

Worksheet S-7

Date/Time Prepared:  
5/23/2014 8:25 am

		1.00	2.00	3.00	4.00
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.				1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.				2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	30	0	30 3.00
4.00		RUL	97	0	97 4.00
5.00		RVX	25	0	25 5.00
6.00		RVL	34	0	34 6.00
7.00		RHX	9	0	9 7.00
8.00		RHL	0	0	0 8.00
9.00		RMX	0	0	0 9.00
10.00		RML	16	0	16 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	416	0	416 12.00
13.00		RUB	991	0	991 13.00
14.00		RUA	730	0	730 14.00
15.00		RVC	386	0	386 15.00
16.00		RVB	423	0	423 16.00
17.00		RVA	234	0	234 17.00
18.00		RHC	47	0	47 18.00
19.00		RHB	21	0	21 19.00
20.00		RHA	21	0	21 20.00
21.00		RMC	15	0	15 21.00
22.00		RMB	30	0	30 22.00
23.00		RMA	14	0	14 23.00
24.00		RLB	0	0	0 24.00
25.00		RLA	0	0	0 25.00
26.00		ES3	0	0	0 26.00
27.00		ES2	0	0	0 27.00
28.00		ES1	5	0	5 28.00
29.00		HE2	0	0	0 29.00
30.00		HE1	0	0	0 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	0	0	0 32.00
33.00		HC2	7	0	7 33.00
34.00		HC1	0	0	0 34.00
35.00		HB2	0	0	0 35.00
36.00		HB1	0	0	0 36.00
37.00		LE2	0	0	0 37.00
38.00		LE1	0	0	0 38.00
39.00		LD2	7	0	7 39.00
40.00		LD1	0	0	0 40.00
41.00		LC2	0	0	0 41.00
42.00		LC1	0	0	0 42.00
43.00		LB2	0	0	0 43.00
44.00		LB1	0	0	0 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	3	0	3 46.00
47.00		CD2	0	0	0 47.00
48.00		CD1	1	0	1 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	15	0	15 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	9	0	9 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	4	0	4 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	0	0	0 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 150059

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

Worksheet S-7

Date/Time Prepared:  
5/23/2014 8:25 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	9	0	9	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	3	0	3	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	3	0	3	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		3,605	0	3,605	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
SNF SERVICES						
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).			26900	26900	201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing			0	0.00	202.00
203.00	Recruitment			0	0.00	203.00
204.00	Retention of employees			0	0.00	204.00
205.00	Training			0	0.00	205.00
206.00	OTHER (SPECIFY)			0	0.00	206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)			2,554,338		207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150059	Period: From 01/01/2013 To 12/31/2013	Worksheet S-10 Date/Time Prepared: 5/23/2014 8:25 am
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			1.00	
<b>Uncompensated and indigent care cost computation</b>				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.336276	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		7,212,384	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		24,079,176	6.00
7.00	Medicaid cost (line 1 times line 6)		8,097,249	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		884,865	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone SCHIP		0	9.00
10.00	Stand-alone SCHIP charges		0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Uncompensated care (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		884,865	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	4,556,266	0	4,556,266
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,532,163	0	1,532,163
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	1,532,163	0	1,532,163
			1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		11,394,612	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		289,638	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		11,104,974	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		3,734,336	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		5,266,499	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		6,151,364	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150059

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

Worksheet A  
Date/Time Prepared:  
5/23/2014 8:25 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		12,383,904		12,315,299	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	579,102	4,977,798	5,556,900	6,035,879	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,456,857	15,350,133	22,806,990	21,948,341	5.00
7.00	00700	OPERATION OF PLANT	1,447,174	4,310,705	5,757,879	5,757,879	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	40,678	334,225	374,903	374,903	8.00
9.00	00900	HOUSEKEEPING	821,774	451,492	1,273,266	1,273,266	9.00
10.00	01000	DIETARY	891,506	1,533,262	2,424,768	650,151	10.00
11.00	01100	CAFETERIA	0	0	0	1,615,336	11.00
13.00	01300	NURSING ADMINISTRATION	712,398	101,797	814,195	814,195	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	484,441	14,651,585	15,136,026	15,785,937	14.00
15.00	01500	PHARMACY	1,872,213	7,036,880	8,909,093	8,909,093	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	567,542	895,308	1,462,850	1,462,850	16.00
17.00	01700	SOCIAL SERVICE	306,198	44,535	350,733	350,733	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	6,208,090	780,395	6,988,485	7,491,485	30.00
31.00	03100	INTENSIVE CARE UNIT	1,926,529	234,100	2,160,629	2,160,629	31.00
41.00	04100	SUBPROVIDER - IIRF	1,259,491	997,062	2,256,553	2,256,553	41.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	2,083,633	2,083,633	2,044,138	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	1,824,576	6,851,101	8,675,677	8,027,056	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,701,153	721,870	2,423,023	2,437,123	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	411,993	483,896	895,889	892,744	55.00
57.00	05700	CT SCAN	233,561	29,410	262,971	262,971	57.00
57.01	03630	ULTRA SOUND	160,255	17,368	177,623	177,623	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	187,169	13,929	201,098	201,098	58.00
59.00	05900	CARDIAC CATHETERIZATION	826,639	239,390	1,066,029	1,227,852	59.00
60.00	06000	LABORATORY	2,381,610	2,911,233	5,292,843	5,346,161	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	13,656	571,755	585,411	585,411	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	972,279	152,020	1,124,299	1,124,297	65.00
66.00	06600	PHYSICAL THERAPY	3,747,966	1,393,060	5,141,026	5,141,027	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	627,588	72,305	699,893	810,660	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,141,284	1,141,284	1,141,284	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	203,423	203,423	203,423	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	76.00
76.01	03021	CARDIAC REHAB	441,458	100,495	541,953	541,953	76.01
76.02	03022	WOMEN'S CENTER	339,321	52,293	391,614	391,614	76.02
76.03	03330	ENDOSCOPY	495,433	105,651	601,084	601,084	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	1,190,184	526,872	1,717,056	1,672,699	90.00
90.01	09001	OUTPATIENT	280,759	111,179	391,938	403,870	90.01
91.00	09100	EMERGENCY	1,874,957	775,924	2,650,881	2,670,881	91.00
91.01	09101	SHORT STAY	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	33,078	17,510	50,588	48,547	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	42,317,628	82,658,782	124,976,410	125,156,045	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	88,748	134,947	223,695	223,695	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,593,655	12,671,851	33,265,506	32,926,590	192.00
192.01	19201	FOUNDATION	154,922	11,882	166,804	166,804	192.01
192.02	19202	CLINICS	785,332	178,914	964,246	964,246	192.02
192.05	19203	PRACTICE MANAGEMENT	393,851	-456,930	-63,079	-63,079	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	349,925	349,925	349,925	192.06
192.08	19205	RIVERVIEW MEDICAL ARTS	0	146,795	146,795	146,795	192.08
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	WORKMED	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	159,281	194.01
200.00		TOTAL (SUM OF LINES 118-199)	64,334,136	95,696,166	160,030,302	160,030,302	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150059

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

Worksheet A  
Date/Time Prepared:  
5/23/2014 8:25 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-434	12,314,865	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-121,935	5,913,944	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-7,671,356	14,276,985	5.00
7.00	00700 OPERATION OF PLANT	-825	5,757,054	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	374,903	8.00
9.00	00900 HOUSEKEEPING	0	1,273,266	9.00
10.00	01000 DIETARY	0	650,151	10.00
11.00	01100 CAFETERIA	-623,717	991,619	11.00
13.00	01300 NURSING ADMINISTRATION	0	814,195	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	15,785,937	14.00
15.00	01500 PHARMACY	0	8,909,093	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-3,562	1,459,288	16.00
17.00	01700 SOCIAL SERVICE	0	350,733	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS	-503,000	6,988,485	30.00
31.00	03100 INTENSIVE CARE UNIT	0	2,160,629	31.00
41.00	04100 SUBPROVIDER - IRF	0	2,256,553	41.00
43.00	04300 NURSERY	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	-112,611	1,931,527	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	-2,936,207	5,090,849	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	-54,809	2,382,314	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	892,744	55.00
57.00	05700 CT SCAN	0	262,971	57.00
57.01	03630 ULTRA SOUND	0	177,623	57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	201,098	58.00
59.00	05900 CARDIAC CATHETERIZATION	-159,289	1,068,563	59.00
60.00	06000 LABORATORY	-58,282	5,287,879	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	585,411	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	1,124,297	65.00
66.00	06600 PHYSICAL THERAPY	0	5,141,027	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	810,660	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	1,141,284	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	203,423	74.00
76.00	03020 OTHER ANCILLARY	0	0	76.00
76.01	03021 CARDIAC REHAB	0	541,953	76.01
76.02	03022 WOMEN'S CENTER	-331	391,283	76.02
76.03	03330 ENDOSCOPY	0	601,084	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	-196,869	1,475,830	90.00
90.01	09001 OUTPATIENT	-100	403,770	90.01
91.00	09100 EMERGENCY	0	2,670,881	91.00
91.01	09101 SHORT STAY	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	-7,855	40,692	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00	SUBTOTALS (SUM OF LINES 1-117)	-12,451,182	112,704,863	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	223,695	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	32,926,590	192.00
192.01	19201 FOUNDATION	0	166,804	192.01
192.02	19202 CLINICS	0	964,246	192.02
192.05	19203 PRACTICE MANAGEMENT	0	-63,079	192.05
192.06	19204 MOB - NOBLESVILLE SQUARE	0	349,925	192.06
192.08	19205 RIVERVIEW MEDICAL ARTS	0	146,795	192.08
193.00	19300 NONPAID WORKERS	0	0	193.00
194.00	07950 WORKMED	0	0	194.00
194.01	07951 MEALS ON WHEELS	0	159,281	194.01
200.00	TOTAL (SUM OF LINES 118-199)	-12,451,182	147,579,120	200.00

RECLASSIFICATIONS

Provider CCN: 150059

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

Worksheet A-6

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		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
<b>A - CAFETERIA RECLASS</b>						
1.00	CAFETERIA	11.00	593,905	1,021,431	1.00	
	TOTALS		593,905	1,021,431		
<b>B - MEALS ON WHEELS</b>						
1.00	MEALS ON WHEELS	194.01	58,562	100,719	1.00	
	TOTALS		58,562	100,719		
<b>C - INSURANCE RECLASS</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	68,605	1.00	
	TOTALS		0	68,605		
<b>D - MED SUPPLY RECLASS</b>						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	474,721	1.00	
2.00	OPERATING ROOM	50.00	0	423	2.00	
3.00	CARDIAC CATHETERIZATION	59.00	0	1,201	3.00	
4.00	PHYSICAL THERAPY	66.00	0	1	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
	TOTALS		0	476,346		
<b>E - RSMA RECLASS</b>						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	478,979	1.00	
2.00	CENTRAL SERVICES & SUPPLY	14.00	175,190	0	2.00	
3.00	OPERATING ROOM	50.00	2,596,892	0	3.00	
	TOTALS		2,772,082	478,979		
<b>F - PHYSICIAN PROFESSIONAL FEES</b>						
1.00	ADULTS & PEDIATRICS	30.00	0	503,000	1.00	
2.00	OPERATING ROOM	50.00	0	5,125	2.00	
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	14,100	3.00	
4.00	CARDIAC CATHETERIZATION	59.00	0	160,622	4.00	
5.00	LABORATORY	60.00	0	55,532	5.00	
6.00	ELECTROCARDIOLOGY	69.00	0	113,125	6.00	
7.00	OUTPATIENT	90.01	0	12,000	7.00	
8.00	EMERGENCY	91.00	0	20,000	8.00	
9.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	43,750	9.00	
	TOTALS		0	927,254		
500.00	Grand Total: Increases		3,424,549	3,073,334	500.00	

RECLASSIFICATIONS

Provider CCN: 150059

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

Worksheet A-6

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Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
<b>A - CAFETERIA RECLASS</b>						
1.00	DIETARY	10.00	593,905	1,021,431	0	1.00
	TOTALS		593,905	1,021,431		
<b>B - MEALS ON WHEELS</b>						
1.00	DIETARY	10.00	58,562	100,719	0	1.00
	TOTALS		58,562	100,719		
<b>C - INSURANCE RECLASS</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	68,605	12	1.00
	TOTALS		0	68,605		
<b>D - MED SUPPLY RECLASS</b>						
1.00	SKILLED NURSING FACILITY	44.00	0	39,495	0	1.00
2.00	RADIOLOGY-THERAPEUTIC	55.00	0	3,145	0	2.00
3.00	LABORATORY	60.00	0	2,214	0	3.00
4.00	RESPIRATORY THERAPY	65.00	0	2	0	4.00
5.00	ELECTROCARDIOLOGY	69.00	0	2,358	0	5.00
6.00	CLINIC	90.00	0	44,357	0	6.00
7.00	OUTPATIENT	90.01	0	68	0	7.00
8.00	AMBULANCE SERVICES	95.00	0	2,041	0	8.00
9.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	382,666	0	9.00
	TOTALS		0	476,346		
<b>E - RSMA RECLASS</b>						
1.00	OPERATING ROOM	50.00	0	478,979	0	1.00
2.00	OPERATING ROOM	50.00	0	2,772,082	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		0	3,251,061		
<b>F - PHYSICIAN PROFESSIONAL FEES</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	927,254	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
	TOTALS		0	927,254		
500.00	Grand Total: Decreases		652,467	5,845,416		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150059

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
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	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	9,814,610	0	0	0	1.00
2.00	Land Improvements	2,418,394	31,949	41,181	73,130	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	96,575,012	8,813,905	-3,599,783	5,214,122	4.00
5.00	Fixed Equipment	33,504,311	326,972	693,094	1,020,066	5.00
6.00	Movable Equipment	66,930,940	3,653,436	2,865,508	6,518,944	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	209,243,267	12,826,262	0	12,826,262	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	209,243,267	12,826,262	0	12,826,262	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	9,814,610	0			1.00
2.00	Land Improvements	2,491,524	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	101,789,134	0			4.00
5.00	Fixed Equipment	34,518,797	0			5.00
6.00	Movable Equipment	72,517,731	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	221,131,796	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	221,131,796	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150059

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
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Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	10,143,976	0	2,027,121	212,807	0	1.00
3.00	Total (sum of lines 1-2)	10,143,976	0	2,027,121	212,807	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	12,383,904		1.00		
3.00	Total (sum of lines 1-2)	0	12,383,904		3.00		

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150059

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	10,143,976	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	10,143,976	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,026,687	144,202	0	0	12,314,865	1.00
3.00	Total (sum of lines 1-2)	2,026,687	144,202	0	0	12,314,865	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150059

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

Worksheet A-8

Date/Time Prepared:  
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	*** Cost Center Deleted ***	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-2,105,043	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	-817,282	0			0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-623,717	0	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts			0		0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	*** Cost Center Deleted ***	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		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

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
33.00 OTHER REVENUES ->HOSPITAL OUTPATIENT	B	-15	ADMINISTRATIVE & GENERAL		5.00	0	33.00
33.01 OTHER REV MEDICAL REPORT	B	-3,562	MEDICAL RECORDS & LIBRARY		16.00	0	33.01
33.02 OTHER REV RADIOLOGY FILM	B	-14	RADIOLOGY-DIAGNOSTIC		54.00	0	33.02
33.03 OTHER REVENUES-OTHER REV-FITNESS	B	-4,277	ADMINISTRATIVE & GENERAL		5.00	0	33.03
33.04 OTHER REVENUES ->PURCHASE DISCOUNTS	B	-37,171	ADMINISTRATIVE & GENERAL		5.00	0	33.04
33.05 OTHER REV ->VHA DIVIDENDS: OTHER	B	-77,463	ADMINISTRATIVE & GENERAL		5.00	0	33.05
33.06 SHERIDAN AMBULANCE - OTHER REVENUE	B	-8,005	AMBULANCE SERVICES		95.00	0	33.06
33.07 SCHOOL FITNESS CONTRACT - OTHER REV	B	-181,444	CLINIC		90.00	0	33.07
33.08 COMM HEALTH CLINIC - OTHER GRANT REV	B	-15,425	CLINIC		90.00	0	33.08
34.00 RADIOLOGY - OTHER REVENUE - SILVER	B	-54,271	RADIOLOGY-DIAGNOSTIC		54.00	0	34.00
36.00 NON-OP EXPENSE INVESTMENT FEES	B	186,746	ADMINISTRATIVE & GENERAL		5.00	0	36.00
38.00 RADIOLOGY-OTHER REVENUE-CDS FOR LEGA	B	-350	RADIOLOGY-DIAGNOSTIC		54.00	0	38.00
39.00 AMBULANCE ->OTHER REVENUE	B	150	AMBULANCE SERVICES		95.00	0	39.00
40.00 LABORATORY -> OTHER REVENUE	B	-57,982	LABORATORY		60.00	0	40.00
41.00 EMPLOYEE WELLNESS- OTHER REVENUE	B	-32,198	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	41.00
42.00 PR/MARKETING- OTHER REVENUE	B	-5,004	ADMINISTRATIVE & GENERAL		5.00	0	42.00
44.00 PHYSICIANS' BILLING -> BILLING FEES	B	-25,678	ADMINISTRATIVE & GENERAL		5.00	0	44.00
45.01 205 CONNER STREET- > RENTAL INCOME	B	-21,072	ADMINISTRATIVE & GENERAL		5.00	0	45.01
45.02 MISCELLANEOUS INTEREST INCOME	B	-46,309	ADMINISTRATIVE & GENERAL		5.00	0	45.02
45.03 INTEREST INCOME - BOND FUNDS	B	-434	NEW CAP REL COSTS-BLDG & FIXT		1.00	11	45.03
45.06 RENTAL INCOME - TCU	B	-112,611	SKILLED NURSING FACILITY		44.00	0	45.06
45.07 COMMUNITY RELATIONS	B	-1,041,892	ADMINISTRATIVE & GENERAL		5.00	0	45.07
45.08 COMMUNITY RELATIONS BENEFITS	B	-15,055	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	45.08
45.09 CRNA	B	-677,390	OPERATING ROOM		50.00	0	45.09
45.10 CRNA BENEFITS	B	-63,129	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	45.10
45.11 PHYSICIAN RECRUITMENT	B	-24,855	ADMINISTRATIVE & GENERAL		5.00	0	45.11
45.12 IHA LOBBYING EXPENSE	A	-2,721	ADMINISTRATIVE & GENERAL		5.00	0	45.12
45.13 HAF EXPENSE	A	-6,570,600	ADMINISTRATIVE & GENERAL		5.00	0	45.13
45.14 EDUCATION - OTHER REVENUE	B	-10,518	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	45.14
45.15 EMPLOYEE HEALTH/INF CONT- OTHER REVE	B	-1,035	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	45.15
45.16 ENGINEERING - ENERGY REBATES	B	-825	OPERATION OF PLANT		7.00	0	45.16
45.18 LABORATORY - HISTOLOGY - OTHER REV	B	-300	LABORATORY		60.00	0	45.18
45.19 WOMENS CTR - OTHER REV	B	-331	WOMEN'S CENTER		76.02	0	45.19
45.20 WOC- NUR HOME - WTA CLASS	B	-100	OUTPATIENT		90.01	0	45.20
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-12,451,182					50.00

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

Provider CCN: 150059

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

Worksheet A-8-1

Date/Time Prepared:  
5/23/2014 8:25 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	50.00	OPERATING ROOM	3,272,134	4,089,416	1.00
2.00	0.00		0	0	2.00
3.00	0.00		0	0	3.00
4.00	0.00		0	0	4.00
5.00	0	0	3,272,134	4,089,416	5.00

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

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

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

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

6.00	B	RSMA	100.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:				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: 150059

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

Worksheet A-8-1

Date/Time Prepared:  
5/23/2014 8:25 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	-817,282	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-817,282			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>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>			

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150059

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

Worksheet A-8-2

Date/Time Prepared:  
5/23/2014 8:25 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	1,045	1,045	0	177,200	0	1.00
2.00	50.00	OPERATING ROOM	269	269	0	208,000	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	174	174	0	225,300	0	3.00
4.00	50.00	OPERATING ROOM	1,441,266	1,441,266	0	208,000	0	4.00
5.00	59.00	CARDIAC CATHETERIZATION	100,000	100,000	0	177,200	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	503,000	503,000	0	177,200	0	6.00
7.00	59.00	CARDIAC CATHETERIZATION	59,289	59,289	0	177,200	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,105,043	2,105,043	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	6.00
7.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	1,045	1.00
2.00	50.00	OPERATING ROOM	0	0	0	269	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	174	3.00
4.00	50.00	OPERATING ROOM	0	0	0	1,441,266	4.00
5.00	59.00	CARDIAC CATHETERIZATION	0	0	0	100,000	5.00
6.00	30.00	ADULTS & PEDIATRICS	0	0	0	503,000	6.00
7.00	59.00	CARDIAC CATHETERIZATION	0	0	0	59,289	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	2,105,043	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150059

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2014 8:25 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT				
	0	1.00	4.00	4A	5.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	12,314,865	12,314,865			1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	5,913,944	61,032	5,974,976		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	14,276,985	957,141	669,723	15,903,849	15,903,849 5.00
7.00 00700	OPERATION OF PLANT	5,757,054	4,653,260	129,975	10,540,289	1,272,793 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	374,903	49,258	3,653	427,814	51,661 8.00
9.00 00900	HOUSEKEEPING	1,273,266	31,063	73,806	1,378,135	166,417 9.00
10.00 01000	DIETARY	650,151	75,344	21,469	746,964	90,200 10.00
11.00 01100	CAFETERIA	991,619	153,002	53,340	1,197,961	144,660 11.00
13.00 01300	NURSING ADMINISTRATION	814,195	0	63,983	878,178	106,044 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	15,785,937	92,717	59,243	15,937,897	1,924,581 14.00
15.00 01500	PHARMACY	8,909,093	147,601	168,149	9,224,843	1,113,946 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,459,288	76,837	50,973	1,587,098	191,650 16.00
17.00 01700	SOCIAL SERVICE	350,733	40,895	27,501	419,129	50,612 17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	6,988,485	1,946,365	557,567	9,492,417	1,146,257 30.00
31.00 03100	INTENSIVE CARE UNIT	2,160,629	342,170	173,027	2,675,826	323,119 31.00
41.00 04100	SUBPROVIDER - IIRF	2,256,553	333,857	113,119	2,703,529	326,465 41.00
43.00 04300	NURSERY	0	0	0	0	0 43.00
44.00 04400	SKILLED NURSING FACILITY	1,931,527	230,362	0	2,161,889	261,059 44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	5,090,849	705,945	397,105	6,193,899	747,944 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,382,314	349,488	152,786	2,884,588	348,328 54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	892,744	176,748	37,002	1,106,494	133,615 55.00
57.00 05700	CT SCAN	262,971	0	20,977	283,948	34,288 57.00
57.01 03630	ULTRA SOUND	177,623	0	14,393	192,016	23,187 57.01
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	201,098	0	16,810	217,908	26,313 58.00
59.00 05900	CARDIAC CATHETERIZATION	1,068,563	71,660	74,243	1,214,466	146,653 59.00
60.00 06000	LABORATORY	5,287,879	305,954	213,900	5,807,733	701,313 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	585,411	91,199	1,226	677,836	81,852 63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	1,124,297	45,898	87,323	1,257,518	151,852 65.00
66.00 06600	PHYSICAL THERAPY	5,141,027	0	336,616	5,477,643	661,453 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00 06900	ELECTROCARDIOLOGY	810,660	266,602	56,366	1,133,628	136,891 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	1,141,284	0	0	1,141,284	137,816 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	203,423	13,217	0	216,640	26,160 74.00
76.00 03020	OTHER ANCILLARY	0	0	0	0	0 76.00
76.01 03021	CARDIAC REHAB	541,953	0	39,649	581,602	70,231 76.01
76.02 03022	WOMEN'S CENTER	391,283	202,534	30,475	624,292	75,386 76.02
76.03 03330	ENDOSCOPY	601,084	62,973	44,496	708,553	85,561 76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	1,475,830	0	106,894	1,582,724	191,122 90.00
90.01 09001	OUTPATIENT	403,770	0	25,216	428,986	51,802 90.01
91.00 09100	EMERGENCY	2,670,881	408,180	168,396	3,247,457	392,147 91.00
91.01 09101	SHORT STAY	0	0	0	0	0 91.01
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	40,692	0	2,971	43,663	5,273 95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	112,704,863	11,891,302	3,992,372	110,298,696	11,398,651 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	223,695	117,882	7,971	349,548	42,210 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	32,926,590	225,558	1,849,553	35,001,701	4,226,685 192.00
192.01 19201	FOUNDATION	166,804	80,123	13,914	260,841	31,498 192.01
192.02 19202	CLINICS	964,246	0	70,533	1,034,779	124,955 192.02
192.05 19203	PRACTICE MANAGEMENT	-63,079	0	35,373	-27,706	0 192.05
192.06 19204	MOB - NOBLESVILLE SQUARE	349,925	0	0	349,925	42,255 192.06
192.08 19205	RIVERVIEW MEDICAL ARTS	146,795	0	0	146,795	17,726 192.08
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
194.00 07950	WORKMED	0	0	0	0	0 194.00
194.01 07951	MEALS ON WHEELS	159,281	0	5,260	164,541	19,869 194.01
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150059

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2014 8:25 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
202.00   TOTAL (sum lines 118-201)	147,579,120	12,314,865		5,974,976	147,579,120	15,903,849	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150059

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2014 8:25 am

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
		7.00	8.00	9.00	10.00	11.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	11,813,082				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	87,589	567,064			8.00	
9.00	00900	HOUSEKEEPING	55,236	0	1,599,788		9.00	
10.00	01000	DIETARY	133,973	0	4,907	976,044	10.00	
11.00	01100	CAFETERIA	272,062	0	45,802	0	11.00	
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	164,866	4,262	1,636	0	14.00	
15.00	01500	PHARMACY	262,458	0	40,894	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	136,629	0	8,179	0	16.00	
17.00	01700	SOCIAL SERVICE	72,718	0	0	0	17.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	3,460,947	177,744	511,998	457,860	30.00	
31.00	03100	INTENSIVE CARE UNIT	608,433	41,437	80,153	75,096	31.00	
41.00	04100	SUBPROVIDER - IRF	593,650	44,304	103,054	241,232	41.00	
43.00	04300	NURSERY	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	409,620	41,127	91,603	201,856	44.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,255,283	29,743	199,565	0	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	621,445	33,207	26,172	0	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	314,286	4,588	8,179	0	55.00	
57.00	05700	CT SCAN	0	0	0	0	57.00	
57.01	03630	ULTRA SOUND	0	0	0	0	57.01	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	1,636	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	127,423	14,631	0	0	59.00	
60.00	06000	LABORATORY	544,036	0	57,252	0	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	162,166	0	0	0	63.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	81,614	0	4,907	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	4,781	6,543	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	474,062	4,867	57,252	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	23,502	0	0	0	74.00	
76.00	03020	OTHER ANCILLARY	0	0	0	0	76.00	
76.01	03021	CARDIAC REHAB	0	418	32,716	0	76.01	
76.02	03022	WOMEN'S CENTER	360,138	2,829	35,987	0	76.02	
76.03	03330	ENDOSCOPY	111,976	25,294	0	0	76.03	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	767	0	0	90.00	
90.01	09001	OUTPATIENT	0	15,406	19,629	0	90.01	
91.00	09100	EMERGENCY	725,809	76,542	139,041	0	91.00	
91.01	09101	SHORT STAY	0	0	0	0	91.01	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00	
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,059,921	521,947	1,477,105	976,044	1,641,569	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	209,612	0	4,907	0	5,609	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	401,078	44,730	85,060	0	0	192.00
192.01	19201	FOUNDATION	142,471	0	0	0	6,705	192.01
192.02	19202	CLINICS	0	201	32,716	0	0	192.02
192.05	19203	PRACTICE MANAGEMENT	0	186	0	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	6,602	194.01
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	11,813,082	567,064	1,599,788	976,044	1,660,485	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150059

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/23/2014 8:25 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	1,007,766					13.00
14.00	01400	0	18,075,381				14.00
15.00	01500	0	0	10,708,492			15.00
16.00	01600	0	0	0	1,966,116		16.00
17.00	01700	0	0	0	0	556,720	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	575,095	0	0	625,267	423,645	30.00
31.00	03100	155,996	0	0	86,843	37,963	31.00
41.00	04100	131,270	0	0	0	50,583	41.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	3,474	44,529	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	0	0	680,845	0	50.00
52.00	05200	0	0	0	0	0	52.00
54.00	05400	0	0	0	6,947	0	54.00
55.00	05500	0	0	0	24,316	0	55.00
57.00	05700	0	0	0	0	0	57.00
57.01	03630	0	0	0	0	0	57.01
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	52,106	0	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	0	0	0	204,948	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	41,684	0	69.00
71.00	07100	0	18,075,381	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	10,708,492	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03020	0	0	0	0	0	76.00
76.01	03021	0	0	0	0	0	76.01
76.02	03022	0	0	0	0	0	76.02
76.03	03330	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
91.00	09100	145,405	0	0	236,212	0	91.00
91.01	09101	0	0	0	0	0	91.01
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		1,007,766	18,075,381	10,708,492	1,962,642	556,720	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	0	3,474	0	192.02
192.05	19203	0	0	0	0	0	192.05
192.06	19204	0	0	0	0	0	192.06
192.08	19205	0	0	0	0	0	192.08
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		1,007,766	18,075,381	10,708,492	1,966,116	556,720	202.00



ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150059

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/23/2014 8:25 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	61,032	61,032	61,032		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	957,141	957,141	6,838	963,979	5.00
7.00 00700	OPERATION OF PLANT	0	4,653,260	4,653,260	1,327	77,144	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	49,258	49,258	37	3,131	8.00
9.00 00900	HOUSEKEEPING	0	31,063	31,063	754	10,087	9.00
10.00 01000	DIETARY	0	75,344	75,344	219	5,467	10.00
11.00 01100	CAFETERIA	0	153,002	153,002	545	8,768	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	653	6,427	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	92,717	92,717	605	116,649	14.00
15.00 01500	PHARMACY	0	147,601	147,601	1,717	67,517	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	76,837	76,837	520	11,616	16.00
17.00 01700	SOCIAL SERVICE	0	40,895	40,895	281	3,068	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	0	1,946,365	1,946,365	5,693	69,475	30.00
31.00 03100	INTENSIVE CARE UNIT	0	342,170	342,170	1,767	19,584	31.00
41.00 04100	SUBPROVIDER - I RF	0	333,857	333,857	1,155	19,787	41.00
43.00 04300	NURSERY	0	0	0	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY	0	230,362	230,362	0	15,823	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	0	705,945	705,945	4,054	45,333	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	349,488	349,488	1,560	21,112	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	176,748	176,748	378	8,098	55.00
57.00 05700	CT SCAN	0	0	0	214	2,078	57.00
57.01 03630	ULTRA SOUND	0	0	0	147	1,405	57.01
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	172	1,595	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	71,660	71,660	758	8,889	59.00
60.00 06000	LABORATORY	0	305,954	305,954	2,184	42,507	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	91,199	91,199	13	4,961	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	45,898	45,898	892	9,204	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	3,437	40,091	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	266,602	266,602	575	8,297	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	8,353	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	13,217	13,217	0	1,586	74.00
76.00 03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01 03021	CARDIAC REHAB	0	0	0	405	4,257	76.01
76.02 03022	WOMEN'S CENTER	0	202,534	202,534	311	4,569	76.02
76.03 03330	ENDOSCOPY	0	62,973	62,973	454	5,186	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000	CLINIC	0	0	0	1,091	11,584	90.00
90.01 09001	OUTPATIENT	0	0	0	257	3,140	90.01
91.00 09100	EMERGENCY	0	408,180	408,180	1,719	23,768	91.00
91.01 09101	SHORT STAY	0	0	0	0	0	91.01
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00 09500	AMBULANCE SERVICES	0	0	0	30	320	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	11,891,302	11,891,302	40,762	690,876	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	117,882	117,882	81	2,558	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	225,558	225,558	18,912	256,223	192.00
192.01 19201	FOUNDATION	0	80,123	80,123	142	1,909	192.01
192.02 19202	CLINICS	0	0	0	720	7,574	192.02
192.05 19203	PRACTICE MANAGEMENT	0	0	0	361	0	192.05
192.06 19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	2,561	192.06
192.08 19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	1,074	192.08
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950	WORKMED	0	0	0	0	0	194.00
194.01 07951	MEALS ON WHEELS	0	0	0	54	1,204	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	12,314,865	12,314,865	61,032	963,979	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150059

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/23/2014 8:25 am

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	4,731,731				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	35,084	87,510			8.00
9.00	00900	HOUSEKEEPING	22,125	0	64,029		9.00
10.00	01000	DIETARY	53,663	0	196	134,889	10.00
11.00	01100	CAFETERIA	108,975	0	1,833	0	273,123
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	3,873
14.00	01400	CENTRAL SERVICES & SUPPLY	66,037	658	65	0	6,931
15.00	01500	PHARMACY	105,128	0	1,637	0	10,914
16.00	01600	MEDICAL RECORDS & LIBRARY	54,727	0	327	0	7,000
17.00	01700	SOCIAL SERVICE	29,127	0	0	0	2,346
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	1,386,280	27,428	20,496	63,277	56,073
31.00	03100	INTENSIVE CARE UNIT	243,708	6,395	3,208	10,378	15,211
41.00	04100	SUBPROVIDER - IRF	237,787	6,837	4,125	33,338	12,800
43.00	04300	NURSERY	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	164,073	6,347	3,666	27,896	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	502,804	4,590	7,987	0	19,949
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	248,920	5,125	1,048	0	14,344
55.00	05500	RADIOLOGY-THERAPEUTIC	125,887	708	327	0	3,235
57.00	05700	CT SCAN	0	0	0	0	2,006
57.01	03630	ULTRA SOUND	0	0	0	0	913
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	65	0	1,159
59.00	05900	CARDIAC CATHETERIZATION	51,039	2,258	0	0	5,483
60.00	06000	LABORATORY	217,914	0	2,291	0	23,624
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	64,956	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	32,691	0	196	0	8,480
66.00	06600	PHYSICAL THERAPY	0	738	262	0	31,630
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	189,885	751	2,291	0	5,021
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	9,414	0	0	0	0
76.00	03020	OTHER ANCILLARY	0	0	0	0	0
76.01	03021	CARDIAC REHAB	0	65	1,309	0	3,328
76.02	03022	WOMEN'S CENTER	144,253	437	1,440	0	3,556
76.03	03330	ENDOSCOPY	44,852	3,903	0	0	4,301
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	118	0	0	10,911
90.01	09001	OUTPATIENT	0	2,377	786	0	2,247
91.00	09100	EMERGENCY	290,723	11,812	5,565	0	14,178
91.01	09101	SHORT STAY	0	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	498
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,430,052	80,547	59,120	134,889	270,011
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	83,960	0	196	0	923
192.00	19200	PHYSICIANS' PRIVATE OFFICES	160,652	6,903	3,404	0	0
192.01	19201	FOUNDATION	57,067	0	0	0	1,103
192.02	19202	CLINICS	0	31	1,309	0	0
192.05	19203	PRACTICE MANAGEMENT	0	29	0	0	0
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	WORKMED	0	0	0	0	0
194.01	07951	MEALS ON WHEELS	0	0	0	0	1,086
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	4,731,731	87,510	64,029	134,889	273,123

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150059

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/23/2014 8:25 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DIETARY						10.00
11.00	01100 CAFETERIA						11.00
13.00	01300 NURSING ADMINISTRATION	10,953					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	283,662				14.00
15.00	01500 PHARMACY	0	0	334,514			15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	151,027		16.00
17.00	01700 SOCIAL SERVICE	0	0	0	0	75,717	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	6,251	0	0	48,030	57,618	30.00
31.00	03100 INTENSIVE CARE UNIT	1,695	0	0	6,671	5,163	31.00
41.00	04100 SUBPROVIDER - IRF	1,427	0	0	0	6,880	41.00
43.00	04300 NURSERY	0	0	0	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	267	6,056	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	52,298	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	534	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	1,868	0	55.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
57.01	03630 ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	4,002	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	15,743	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	3,202	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	283,662	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	334,514	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020 OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03021 CARDIAC REHAB	0	0	0	0	0	76.01
76.02	03022 WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330 ENDOSCOPY	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 OUTPATIENT	0	0	0	0	0	90.01
91.00	09100 EMERGENCY	1,580	0	0	18,145	0	91.00
91.01	09101 SHORT STAY	0	0	0	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	10,953	283,662	334,514	150,760	75,717	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201 FOUNDATION	0	0	0	0	0	192.01
192.02	19202 CLINICS	0	0	0	267	0	192.02
192.05	19203 PRACTICE MANAGEMENT	0	0	0	0	0	192.05
192.06	19204 MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.08	19205 RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950 WORKMED	0	0	0	0	0	194.00
194.01	07951 MEALS ON WHEELS	0	0	0	0	0	194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	10,953	283,662	334,514	151,027	75,717	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150059

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/23/2014 8:25 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500 ADMINISTRATIVE & GENERAL				5.00
7.00	00700 OPERATION OF PLANT				7.00
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00	00900 HOUSEKEEPING				9.00
10.00	01000 DIETARY				10.00
11.00	01100 CAFETERIA				11.00
13.00	01300 NURSING ADMINISTRATION				13.00
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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS	3,686,986	0	3,686,986	30.00
31.00	03100 INTENSIVE CARE UNIT	655,950	0	655,950	31.00
41.00	04100 SUBPROVIDER - IRF	657,993	0	657,993	41.00
43.00	04300 NURSERY	0	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	454,490	0	454,490	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	1,342,960	0	1,342,960	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	642,131	0	642,131	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	317,249	0	317,249	55.00
57.00	05700 CT SCAN	4,298	0	4,298	57.00
57.01	03630 ULTRA SOUND	2,465	0	2,465	57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2,991	0	2,991	58.00
59.00	05900 CARDIAC CATHETERIZATION	140,087	0	140,087	59.00
60.00	06000 LABORATORY	598,476	0	598,476	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	161,129	0	161,129	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	97,361	0	97,361	65.00
66.00	06600 PHYSICAL THERAPY	91,901	0	91,901	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	476,624	0	476,624	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	283,662	0	283,662	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	8,353	0	8,353	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	334,514	0	334,514	73.00
74.00	07400 RENAL DIALYSIS	24,217	0	24,217	74.00
76.00	03020 OTHER ANCILLARY	0	0	0	76.00
76.01	03021 CARDIAC REHAB	9,364	0	9,364	76.01
76.02	03022 WOMEN'S CENTER	357,100	0	357,100	76.02
76.03	03330 ENDOSCOPY	121,669	0	121,669	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	23,704	0	23,704	90.00
90.01	09001 OUTPATIENT	8,807	0	8,807	90.01
91.00	09100 EMERGENCY	775,670	0	775,670	91.00
91.01	09101 SHORT STAY	0	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES	848	0	848	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00	SUBTOTALS (SUM OF LINES 1-117)	11,280,999	0	11,280,999	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	205,600	0	205,600	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	671,652	0	671,652	192.00
192.01	19201 FOUNDATION	140,344	0	140,344	192.01
192.02	19202 CLINICS	9,901	0	9,901	192.02
192.05	19203 PRACTICE MANAGEMENT	390	0	390	192.05
192.06	19204 MOB - NOBLESVILLE SQUARE	2,561	0	2,561	192.06
192.08	19205 RIVERVIEW MEDICAL ARTS	1,074	0	1,074	192.08
193.00	19300 NONPAID WORKERS	0	0	0	193.00
194.00	07950 WORKMED	0	0	0	194.00
194.01	07951 MEALS ON WHEELS	2,344	0	2,344	194.01
200.00	Cross Foot Adjustments	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	12,314,865	0	12,314,865	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150059

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

Worksheet B-1  
Date/Time Prepared:  
5/23/2014 8:25 am

Cost Center Description	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)					
	1.00	4.00	5A	5.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	494,761					1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	2,452	66,527,116				4.00
5.00 00500 ADMINISTRATIVE & GENERAL	38,454	7,456,857	-15,903,849	131,702,977		5.00
7.00 00700 OPERATION OF PLANT	186,949	1,447,174	0	10,540,289	266,906	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	1,979	40,678	0	427,814	1,979	8.00
9.00 00900 HOUSEKEEPING	1,248	821,774	0	1,378,135	1,248	9.00
10.00 01000 DIETARY	3,027	239,039	0	746,964	3,027	10.00
11.00 01100 CAFETERIA	6,147	593,905	0	1,197,961	6,147	11.00
13.00 01300 NURSING ADMINISTRATION	0	712,398	0	878,178	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	3,725	659,631	0	15,937,897	3,725	14.00
15.00 01500 PHARMACY	5,930	1,872,213	0	9,224,843	5,930	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	3,087	567,542	0	1,587,098	3,087	16.00
17.00 01700 SOCIAL SERVICE	1,643	306,198	0	419,129	1,643	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	78,197	6,208,090	0	9,492,417	78,197	30.00
31.00 03100 INTENSIVE CARE UNIT	13,747	1,926,529	0	2,675,826	13,747	31.00
41.00 04100 SUBPROVIDER - IIRF	13,413	1,259,491	0	2,703,529	13,413	41.00
43.00 04300 NURSERY	0	0	0	0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	9,255	0	0	2,161,889	9,255	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	28,362	4,421,468	0	6,193,899	28,362	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	14,041	1,701,153	0	2,884,588	14,041	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	7,101	411,993	0	1,106,494	7,101	55.00
57.00 05700 CT SCAN	0	233,561	0	283,948	0	57.00
57.01 03630 ULTRA SOUND	0	160,255	0	192,016	0	57.01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	187,169	0	217,908	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	2,879	826,639	0	1,214,466	2,879	59.00
60.00 06000 LABORATORY	12,292	2,381,610	0	5,807,733	12,292	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	3,664	13,656	0	677,836	3,664	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	1,844	972,279	0	1,257,518	1,844	65.00
66.00 06600 PHYSICAL THERAPY	0	3,747,966	0	5,477,643	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	10,711	627,588	0	1,133,628	10,711	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,141,284	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	531	0	0	216,640	531	74.00
76.00 03020 OTHER ANCILLARY	0	0	0	0	0	76.00
76.01 03021 CARDIAC REHAB	0	441,458	0	581,602	0	76.01
76.02 03022 WOMEN'S CENTER	8,137	339,321	0	624,292	8,137	76.02
76.03 03330 ENDOSCOPY	2,530	495,433	0	708,553	2,530	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	1,190,184	0	1,582,724	0	90.00
90.01 09001 OUTPATIENT	0	280,759	0	428,986	0	90.01
91.00 09100 EMERGENCY	16,399	1,874,957	0	3,247,457	16,399	91.00
91.01 09101 SHORT STAY	0	0	0	0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES	0	33,078	0	43,663	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00 SUBTOTALS (SUM OF LINES 1-117)	477,744	44,452,046	-15,903,849	94,394,847	249,889	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,736	88,748	0	349,548	4,736	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	9,062	20,593,655	0	35,001,701	9,062	192.00
192.01 19201 FOUNDATION	3,219	154,922	0	260,841	3,219	192.01
192.02 19202 CLINICS	0	785,332	0	1,034,779	0	192.02
192.05 19203 PRACTICE MANAGEMENT	0	393,851	27,706	0	0	192.05
192.06 19204 MOB - NOBLESVILLE SQUARE	0	0	0	349,925	0	192.06
192.08 19205 RIVERVIEW MEDICAL ARTS	0	0	0	146,795	0	192.08
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950 WORKMED	0	0	0	0	0	194.00
194.01 07951 MEALS ON WHEELS	0	58,562	0	164,541	0	194.01
200.00						200.00
201.00						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150059

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

Worksheet B-1

Date/Time Prepared:  
5/23/2014 8:25 am

Cost Center Description	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)					
	1.00	4.00	5A	5.00	7.00	
202.00 Cost to be allocated (per Wkst. B, Part I)	12,314,865	5,974,976		15,903,849	11,813,082	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	24.890533	0.089813		0.120755	44.259335	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)		61,032		963,979	4,731,731	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)		0.000917		0.007319	17.728080	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150059

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

Worksheet B-1

Date/Time Prepared:  
5/23/2014 8:25 am

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)		
		8.00	9.00	10.00	11.00	13.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT					7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	73,174				8.00	
9.00	00900	HOUSEKEEPING	0	978			9.00	
10.00	01000	DIETARY	0	3	83,313		10.00	
11.00	01100	CAFETERIA	0	28	0	1,230,625	11.00	
13.00	01300	NURSING ADMINISTRATION	0	0	0	17,449	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	550	1	0	31,230	14.00	
15.00	01500	PHARMACY	0	25	0	49,174	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5	0	31,542	16.00	
17.00	01700	SOCIAL SERVICE	0	0	0	10,569	17.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	22,936	313	39,082	252,660	30.00	
31.00	03100	INTENSIVE CARE UNIT	5,347	49	6,410	68,535	31.00	
41.00	04100	SUBPROVIDER - IRF	5,717	63	20,591	57,672	41.00	
43.00	04300	NURSERY	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	5,307	56	17,230	0	44.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	3,838	122	0	89,884	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,285	16	0	64,629	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	592	5	0	14,575	55.00	
57.00	05700	CT SCAN	0	0	0	9,038	57.00	
57.01	03630	ULTRA SOUND	0	0	0	4,116	57.01	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1	0	5,223	58.00	
59.00	05900	CARDIAC CATHETERIZATION	1,888	0	0	24,706	59.00	
60.00	06000	LABORATORY	0	35	0	106,446	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0	3	0	38,211	65.00	
66.00	06600	PHYSICAL THERAPY	617	4	0	142,516	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	628	35	0	22,624	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00	
76.00	03020	OTHER ANCILLARY	0	0	0	0	76.00	
76.01	03021	CARDIAC REHAB	54	20	0	14,995	76.01	
76.02	03022	WOMEN'S CENTER	365	22	0	16,022	76.02	
76.03	03330	ENDOSCOPY	3,264	0	0	19,378	76.03	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	99	0	0	49,162	90.00	
90.01	09001	OUTPATIENT	1,988	12	0	10,123	90.01	
91.00	09100	EMERGENCY	9,877	85	0	63,882	91.00	
91.01	09101	SHORT STAY	0	0	0	0	91.01	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	2,245	95.00	
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	67,352	903	83,313	1,216,606	442,749	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3	0	4,157	190.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,772	52	0	0	192.00	
192.01	19201	FOUNDATION	0	0	0	4,969	192.01	
192.02	19202	CLINICS	26	20	0	0	192.02	
192.05	19203	PRACTICE MANAGEMENT	24	0	0	0	192.05	
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	192.06	
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	192.08	
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00	
194.00	07950	WORKMED	0	0	0	0	194.00	
194.01	07951	MEALS ON WHEELS	0	0	0	4,893	194.01	
200.00		Cross Foot Adjustments					200.00	
201.00		Negative Cost Centers					201.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	567,064	1,599,788	976,044	1,660,485	1,007,766	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150059

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

Worksheet B-1

Date/Time Prepared:  
5/23/2014 8:25 am

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
		8.00	9.00	10.00	11.00	13.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	7.749529	1,635.775051	11.715387	1.349302	2.276156	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	87,510	64,029	134,889	273,123	10,953	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.195917	65.469325	1.619063	0.221938	0.024739	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150059

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

Worksheet B-1

Date/Time Prepared:  
5/23/2014 8:25 am

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100					1.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300					13.00
14.00	01400	1,000				14.00
15.00	01500	0	1,000			15.00
16.00	01600	0	0	566		16.00
17.00	01700	0	0	0	5,426	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	0	0	180	4,129	30.00
31.00	03100	0	0	25	370	31.00
41.00	04100	0	0	0	493	41.00
43.00	04300	0	0	0	0	43.00
44.00	04400	0	0	1	434	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	0	0	196	0	50.00
52.00	05200	0	0	0	0	52.00
54.00	05400	0	0	2	0	54.00
55.00	05500	0	0	7	0	55.00
57.00	05700	0	0	0	0	57.00
57.01	03630	0	0	0	0	57.01
58.00	05800	0	0	0	0	58.00
59.00	05900	0	0	0	0	59.00
60.00	06000	0	0	15	0	60.00
60.01	06001	0	0	0	0	60.01
63.00	06300	0	0	0	0	63.00
64.00	06400	0	0	0	0	64.00
65.00	06500	0	0	0	0	65.00
66.00	06600	0	0	59	0	66.00
67.00	06700	0	0	0	0	67.00
68.00	06800	0	0	0	0	68.00
69.00	06900	0	0	12	0	69.00
71.00	07100	1,000	0	0	0	71.00
72.00	07200	0	0	0	0	72.00
73.00	07300	0	1,000	0	0	73.00
74.00	07400	0	0	0	0	74.00
76.00	03020	0	0	0	0	76.00
76.01	03021	0	0	0	0	76.01
76.02	03022	0	0	0	0	76.02
76.03	03330	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	0	0	0	0	90.00
90.01	09001	0	0	0	0	90.01
91.00	09100	0	0	68	0	91.00
91.01	09101	0	0	0	0	91.01
92.00	09200	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	0	0	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		1,000	1,000	565	5,426	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	0	0	0	0	190.00
192.00	19200	0	0	0	0	192.00
192.01	19201	0	0	0	0	192.01
192.02	19202	0	0	1	0	192.02
192.05	19203	0	0	0	0	192.05
192.06	19204	0	0	0	0	192.06
192.08	19205	0	0	0	0	192.08
193.00	19300	0	0	0	0	193.00
194.00	07950	0	0	0	0	194.00
194.01	07951	0	0	0	0	194.01
200.00						200.00
201.00						201.00
202.00		18,075,381	10,708,492	1,966,116	556,720	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150059

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

Worksheet B-1

Date/Time Prepared:  
5/23/2014 8:25 am

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)		
		14.00	15.00	16.00	17.00		
203.00	Unit cost multiplier (Wkst. B, Part I)	18,075.381000	10,708.492000	3,473.703180	102.602285		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	283,662	334,514	151,027	75,717		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	283.662000	334.514000	266.832155	13.954478		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150059

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/23/2014 8:25 am

		Title XVII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS		17,212,143	0	17,212,143	30.00	
31.00	03100 INTENSIVE CARE UNIT		4,177,340	0	4,177,340	31.00	
41.00	04100 SUBPROVIDER - IRF		4,271,904	0	4,271,904	41.00	
43.00	04300 NURSERY		0	0	0	43.00	
44.00	04400 SKILLED NURSING FACILITY		3,215,157	0	3,215,157	44.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM		9,228,560	0	9,228,560	50.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM		0	0	0	52.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		4,007,891	0	4,007,891	54.00	
55.00	05500 RADIOLOGY-THERAPEUTIC		1,611,144	0	1,611,144	55.00	
57.00	05700 CT SCAN		330,431	0	330,431	57.00	
57.01	03630 ULTRA SOUND		220,757	0	220,757	57.01	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		252,904	0	252,904	58.00	
59.00	05900 CARDIAC CATHETERIZATION		1,536,509	0	1,536,509	59.00	
60.00	06000 LABORATORY		7,306,068	0	7,306,068	60.00	
60.01	06001 BLOOD LABORATORY		0	0	0	60.01	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		921,854	0	921,854	63.00	
64.00	06400 INTRAVENOUS THERAPY		0	0	0	64.00	
65.00	06500 RESPIRATORY THERAPY	0	1,547,449	0	1,547,449	65.00	
66.00	06600 PHYSICAL THERAPY	0	6,547,665	0	6,547,665	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00	
69.00	06900 ELECTROCARDIOLOGY		1,878,911	0	1,878,911	69.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		18,075,381	0	18,075,381	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		1,279,100	0	1,279,100	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		10,708,492	0	10,708,492	73.00	
74.00	07400 RENAL DIALYSIS		266,302	0	266,302	74.00	
76.00	03020 OTHER ANCILLARY		0	0	0	76.00	
76.01	03021 CARDIAC REHAB		705,200	0	705,200	76.01	
76.02	03022 WOMEN'S CENTER		1,120,251	0	1,120,251	76.02	
76.03	03330 ENDOSCOPY		957,531	0	957,531	76.03	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC		1,840,947	0	1,840,947	90.00	
90.01	09001 OUTPATIENT		529,482	0	529,482	90.01	
91.00	09100 EMERGENCY		5,048,809	0	5,048,809	91.00	
91.01	09101 SHORT STAY		0	0	0	91.01	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		2,388,945	0	2,388,945	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES		51,965	0	51,965	95.00	
200.00	Subtotal (see instructions)	0	107,239,092	0	107,239,092	200.00	
201.00	Less Observation Beds		2,388,945	0	2,388,945	201.00	
202.00	Total (see instructions)	0	104,850,147	0	104,850,147	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150059

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/23/2014 8:25 am

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	21,873,622		21,873,622			30.00
31.00	03100	INTENSIVE CARE UNIT	6,139,375		6,139,375			31.00
41.00	04100	SUBPROVIDER - IRF	6,016,014		6,016,014			41.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	2,554,338		2,554,338			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	21,985,031	22,075,415	44,060,446	0.209452	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,806,750	12,492,913	14,299,663	0.280279	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	150,380	6,588,788	6,739,168	0.239072	0.000000	55.00
57.00	05700	CT SCAN	1,576,401	7,869,976	9,446,377	0.034980	0.000000	57.00
57.01	03630	ULTRA SOUND	299,416	2,169,791	2,469,207	0.089404	0.000000	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	381,785	3,022,227	3,404,012	0.074296	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,004,680	7,412,885	11,417,565	0.134574	0.000000	59.00
60.00	06000	LABORATORY	11,217,395	25,781,951	36,999,346	0.197465	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,061,887	561,846	1,623,733	0.567737	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	3,324,997	841,503	4,166,500	0.371403	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	7,892,539	10,274,560	18,167,099	0.360413	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,855,771	7,660,923	9,516,694	0.197433	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,938,831	18,996,339	46,935,170	0.385114	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,710,706	3,329,789	5,040,495	0.253765	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,927,492	7,605,935	19,533,427	0.548214	0.000000	73.00
74.00	07400	RENAL DIALYSIS	347,405	0	347,405	0.766546	0.000000	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03021	CARDIAC REHAB	261,178	1,715,289	1,976,467	0.356798	0.000000	76.01
76.02	03022	WOMEN'S CENTER	9,148	3,633,691	3,642,839	0.307521	0.000000	76.02
76.03	03330	ENDOSCOPY	975,188	5,217,603	6,192,791	0.154620	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	3,663,752	3,663,752	0.502476	0.000000	90.00
90.01	09001	OUTPATIENT	182,716	1,353,244	1,535,960	0.344724	0.000000	90.01
91.00	09100	EMERGENCY	2,531,706	18,256,019	20,787,725	0.242875	0.000000	91.00
91.01	09101	SHORT STAY	0	0	0	0.000000	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	560,251	2,688,527	3,248,778	0.735336	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	138,585,002	173,212,966	311,797,968			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	138,585,002	173,212,966	311,797,968			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150059	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/23/2014 8:25 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
INPATIENT ROUTINE SERVICE COST CENTERS		11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.209452		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.280279		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.239072		55.00
57.00	05700 CT SCAN	0.034980		57.00
57.01	03630 ULTRA SOUND	0.089404		57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.074296		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.134574		59.00
60.00	06000 LABORATORY	0.197465		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.567737		63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.371403		65.00
66.00	06600 PHYSICAL THERAPY	0.360413		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.197433		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.385114		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.253765		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.548214		73.00
74.00	07400 RENAL DIALYSIS	0.766546		74.00
76.00	03020 OTHER ANCILLARY	0.000000		76.00
76.01	03021 CARDIAC REHAB	0.356798		76.01
76.02	03022 WOMEN'S CENTER	0.307521		76.02
76.03	03330 ENDOSCOPY	0.154620		76.03
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.502476		90.00
90.01	09001 OUTPATIENT	0.344724		90.01
91.00	09100 EMERGENCY	0.242875		91.00
91.01	09101 SHORT STAY	0.000000		91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.735336		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150059

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/23/2014 8:25 am

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS		17,212,143	0	17,212,143	30.00	
31.00	03100 INTENSIVE CARE UNIT		4,177,340	0	4,177,340	31.00	
41.00	04100 SUBPROVIDER - I RF		4,271,904	0	4,271,904	41.00	
43.00	04300 NURSERY		0	0	0	43.00	
44.00	04400 SKILLED NURSING FACILITY		3,215,157	0	3,215,157	44.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM		9,228,560	0	9,228,560	50.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM		0	0	0	52.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		4,007,891	0	4,007,891	54.00	
55.00	05500 RADIOLOGY-THERAPEUTIC		1,611,144	0	1,611,144	55.00	
57.00	05700 CT SCAN		330,431	0	330,431	57.00	
57.01	03630 ULTRA SOUND		220,757	0	220,757	57.01	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		252,904	0	252,904	58.00	
59.00	05900 CARDIAC CATHETERIZATION		1,536,509	0	1,536,509	59.00	
60.00	06000 LABORATORY		7,306,068	0	7,306,068	60.00	
60.01	06001 BLOOD LABORATORY		0	0	0	60.01	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		921,854	0	921,854	63.00	
64.00	06400 INTRAVENOUS THERAPY		0	0	0	64.00	
65.00	06500 RESPIRATORY THERAPY	0	1,547,449	0	1,547,449	65.00	
66.00	06600 PHYSICAL THERAPY	0	6,547,665	0	6,547,665	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00	
69.00	06900 ELECTROCARDIOLOGY		1,878,911	0	1,878,911	69.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		18,075,381	0	18,075,381	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		1,279,100	0	1,279,100	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		10,708,492	0	10,708,492	73.00	
74.00	07400 RENAL DIALYSIS		266,302	0	266,302	74.00	
76.00	03020 OTHER ANCILLARY		0	0	0	76.00	
76.01	03021 CARDIAC REHAB		705,200	0	705,200	76.01	
76.02	03022 WOMEN'S CENTER		1,120,251	0	1,120,251	76.02	
76.03	03330 ENDOSCOPY		957,531	0	957,531	76.03	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC		1,840,947	0	1,840,947	90.00	
90.01	09001 OUTPATIENT		529,482	0	529,482	90.01	
91.00	09100 EMERGENCY		5,048,809	0	5,048,809	91.00	
91.01	09101 SHORT STAY		0	0	0	91.01	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		2,388,945	0	2,388,945	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES		51,965	0	51,965	95.00	
200.00	Subtotal (see instructions)	0	107,239,092	0	107,239,092	200.00	
201.00	Less Observation Beds		2,388,945		2,388,945	201.00	
202.00	Total (see instructions)	0	104,850,147	0	104,850,147	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150059

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/23/2014 8:25 am

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	21,873,622		21,873,622		30.00
31.00	03100	INTENSIVE CARE UNIT	6,139,375		6,139,375		31.00
41.00	04100	SUBPROVIDER - IRF	6,016,014		6,016,014		41.00
43.00	04300	NURSERY	0		0		43.00
44.00	04400	SKILLED NURSING FACILITY	2,554,338		2,554,338		44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	21,985,031	22,075,415	44,060,446	0.209452	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,806,750	12,492,913	14,299,663	0.280279	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	150,380	6,588,788	6,739,168	0.239072	55.00
57.00	05700	CT SCAN	1,576,401	7,869,976	9,446,377	0.034980	57.00
57.01	03630	ULTRA SOUND	299,416	2,169,791	2,469,207	0.089404	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	381,785	3,022,227	3,404,012	0.074296	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,004,680	7,412,885	11,417,565	0.134574	59.00
60.00	06000	LABORATORY	11,217,395	25,781,951	36,999,346	0.197465	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,061,887	561,846	1,623,733	0.567737	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	3,324,997	841,503	4,166,500	0.371403	65.00
66.00	06600	PHYSICAL THERAPY	7,892,539	10,274,560	18,167,099	0.360413	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,855,771	7,660,923	9,516,694	0.197433	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,938,831	18,996,339	46,935,170	0.385114	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,710,706	3,329,789	5,040,495	0.253765	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,927,492	7,605,935	19,533,427	0.548214	73.00
74.00	07400	RENAL DIALYSIS	347,405	0	347,405	0.766546	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0.000000	76.00
76.01	03021	CARDIAC REHAB	261,178	1,715,289	1,976,467	0.356798	76.01
76.02	03022	WOMEN'S CENTER	9,148	3,633,691	3,642,839	0.307521	76.02
76.03	03330	ENDOSCOPY	975,188	5,217,603	6,192,791	0.154620	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	3,663,752	3,663,752	0.502476	90.00
90.01	09001	OUTPATIENT	182,716	1,353,244	1,535,960	0.344724	90.01
91.00	09100	EMERGENCY	2,531,706	18,256,019	20,787,725	0.242875	91.00
91.01	09101	SHORT STAY	0	0	0	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	560,251	2,688,527	3,248,778	0.735336	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
200.00		Subtotal (see instructions)	138,585,002	173,212,966	311,797,968		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	138,585,002	173,212,966	311,797,968		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 150059	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/23/2014 8:25 am
Cost Center Description			PPS Inpatient Ratio 11.00	Title XIX	Hospital Cost
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
57.00	05700	CT SCAN	0.000000		57.00
57.01	03630	ULTRA SOUND	0.000000		57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03020	OTHER ANCILLARY	0.000000		76.00
76.01	03021	CARDIAC REHAB	0.000000		76.01
76.02	03022	WOMEN'S CENTER	0.000000		76.02
76.03	03330	ENDOSCOPY	0.000000		76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	OUTPATIENT	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
91.01	09101	SHORT STAY	0.000000		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 150059

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

Worksheet D  
Part I  
Date/Time Prepared:  
5/23/2014 8:25 am

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,686,986	0	3,686,986	15,152	243.33	30.00
31.00	INTENSIVE CARE UNIT	655,950		655,950	3,109	210.98	31.00
41.00	SUBPROVIDER - IRF	657,993	0	657,993	6,108	107.73	41.00
43.00	NURSERY	0		0	0	0.00	43.00
44.00	SKILLED NURSING FACILITY	454,490		454,490	5,234	86.83	44.00
200.00	Total (Lines 30-199)	5,455,419		5,455,419	29,603		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	5,035	1,225,167				
31.00	INTENSIVE CARE UNIT	1,983	418,373				
41.00	SUBPROVIDER - IRF	4,041	435,337				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	3,605	313,022				
200.00	Total (Lines 30-199)	14,664	2,391,899				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150059	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/23/2014 8:25 am
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Cost Center Description		Title XVIII			Hospital	PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	1,342,960	44,060,446	0.030480	11,497,192	350,434	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	642,131	14,299,663	0.044905	976,700	43,859	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	317,249	6,739,168	0.047075	90,524	4,261	55.00
57.00	05700 CT SCAN	4,298	9,446,377	0.000455	751,272	342	57.00
57.01	03630 ULTRA SOUND	2,465	2,469,207	0.000998	132,169	132	57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2,991	3,404,012	0.000879	164,744	145	58.00
59.00	05900 CARDIAC CATHETERIZATION	140,087	11,417,565	0.012269	1,374,721	16,866	59.00
60.00	06000 LABORATORY	598,476	36,999,346	0.016175	5,082,977	82,217	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	161,129	1,623,733	0.099234	378,491	37,559	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	97,361	4,166,500	0.023368	1,813,654	42,381	65.00
66.00	06600 PHYSICAL THERAPY	91,901	18,167,099	0.005059	845,847	4,279	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	476,624	9,516,694	0.050083	1,051,438	52,659	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	283,662	46,935,170	0.006044	11,937,905	72,153	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	8,353	5,040,495	0.001657	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	334,514	19,533,427	0.017125	4,721,891	80,862	73.00
74.00	07400 RENAL DIALYSIS	24,217	347,405	0.069708	196,081	13,668	74.00
76.00	03020 OTHER ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03021 CARDIAC REHAB	9,364	1,976,467	0.004738	91,494	433	76.01
76.02	03022 WOMEN'S CENTER	357,100	3,642,839	0.098028	1,052	103	76.02
76.03	03330 ENDOSCOPY	121,669	6,192,791	0.019647	99,249	1,950	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	23,704	3,663,752	0.006470	0	0	90.00
90.01	09001 OUTPATIENT	8,807	1,535,960	0.005734	57,363	329	90.01
91.00	09100 EMERGENCY	775,670	20,787,725	0.037314	1,314,573	49,052	91.00
91.01	09101 SHORT STAY	0	0	0.000000	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	511,731	3,248,778	0.157515	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	6,336,463	275,214,619		42,579,337	853,684	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150059		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part III Date/Time Prepared: 5/23/2014 8:25 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
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	15,152	0.00	5,035	0		30.00
31.00	03100	INTENSIVE CARE UNIT	3,109	0.00	1,983	0		31.00
41.00	04100	SUBPROVIDER - IRF	6,108	0.00	4,041	0		41.00
43.00	04300	NURSERY	0	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	5,234	0.00	3,605	0		44.00
200.00		Total (lines 30-199)	29,603		14,664	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150059

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/23/2014 8:25 am

Cost Center Description		Title XVIII				Hospital	PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	76.00
76.01	03021	CARDIAC REHAB	0	0	0	0	76.01
76.02	03022	WOMEN'S CENTER	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	91.00
91.01	09101	SHORT STAY	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150059	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/23/2014 8:25 am
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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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	44,060,446	0.000000	0.000000	11,497,192	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	14,299,663	0.000000	0.000000	976,700	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	6,739,168	0.000000	0.000000	90,524	55.00
57.00	05700 CT SCAN	0	9,446,377	0.000000	0.000000	751,272	57.00
57.01	03630 ULTRA SOUND	0	2,469,207	0.000000	0.000000	132,169	57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	3,404,012	0.000000	0.000000	164,744	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	11,417,565	0.000000	0.000000	1,374,721	59.00
60.00	06000 LABORATORY	0	36,999,346	0.000000	0.000000	5,082,977	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	1,623,733	0.000000	0.000000	378,491	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	4,166,500	0.000000	0.000000	1,813,654	65.00
66.00	06600 PHYSICAL THERAPY	0	18,167,099	0.000000	0.000000	845,847	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	9,516,694	0.000000	0.000000	1,051,438	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	46,935,170	0.000000	0.000000	11,937,905	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	5,040,495	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	19,533,427	0.000000	0.000000	4,721,891	73.00
74.00	07400 RENAL DIALYSIS	0	347,405	0.000000	0.000000	196,081	74.00
76.00	03020 OTHER ANCILLARY	0	0	0.000000	0.000000	0	76.00
76.01	03021 CARDIAC REHAB	0	1,976,467	0.000000	0.000000	91,494	76.01
76.02	03022 WOMEN'S CENTER	0	3,642,839	0.000000	0.000000	1,052	76.02
76.03	03330 ENDOSCOPY	0	6,192,791	0.000000	0.000000	99,249	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	3,663,752	0.000000	0.000000	0	90.00
90.01	09001 OUTPATIENT	0	1,535,960	0.000000	0.000000	57,363	90.01
91.00	09100 EMERGENCY	0	20,787,725	0.000000	0.000000	1,314,573	91.00
91.01	09101 SHORT STAY	0	0	0.000000	0.000000	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	3,248,778	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	0	275,214,619			42,579,337	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150059

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/23/2014 8:25 am

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0	4,442,314	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	3,740,826	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	2,402,069	0	55.00
57.00	05700 CT SCAN	0	2,729,284	0	57.00
57.01	03630 ULTRA SOUND	0	359,920	0	57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	958,170	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	3,475,433	0	59.00
60.00	06000 LABORATORY	0	464,123	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	148,201	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	263,415	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	2,626,313	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,717,660	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2,175,818	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
76.00	03020 OTHER ANCILLARY	0	0	0	76.00
76.01	03021 CARDIAC REHAB	0	1,063,499	0	76.01
76.02	03022 WOMEN'S CENTER	0	241,074	0	76.02
76.03	03330 ENDOSCOPY	0	1,321,557	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0	863,927	0	90.00
90.01	09001 OUTPATIENT	0	794,237	0	90.01
91.00	09100 EMERGENCY	0	3,168,799	0	91.00
91.01	09101 SHORT STAY	0	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	922,993	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (Lines 50-199)	0	38,879,632	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150059	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/23/2014 8:25 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.209452	4,442,314	0	0	930,452	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.280279	3,740,826	0	0	1,048,475	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.239072	2,402,069	0	0	574,267	55.00
57.00	05700 CT SCAN	0.034980	2,729,284	0	0	95,470	57.00
57.01	03630 ULTRA SOUND	0.089404	359,920	0	0	32,178	57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.074296	958,170	2	395	71,188	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.134574	3,475,433	0	0	467,703	59.00
60.00	06000 LABORATORY	0.197465	464,123	3,923	0	91,648	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.567737	148,201	0	0	84,139	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.371403	263,415	0	0	97,833	65.00
66.00	06600 PHYSICAL THERAPY	0.360413	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.197433	2,626,313	0	0	518,521	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.385114	6,717,660	10	2,154	2,587,065	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.253765	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.548214	2,175,818	46	9,718	1,192,814	73.00
74.00	07400 RENAL DIALYSIS	0.766546	0	0	0	0	74.00
76.00	03020 OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03021 CARDIAC REHAB	0.356798	1,063,499	0	0	379,454	76.01
76.02	03022 WOMEN'S CENTER	0.307521	241,074	0	0	74,135	76.02
76.03	03330 ENDOSCOPY	0.154620	1,321,557	0	0	204,339	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.502476	863,927	1	138	434,103	90.00
90.01	09001 OUTPATIENT	0.344724	794,237	3	709	273,793	90.01
91.00	09100 EMERGENCY	0.242875	3,168,799	0	0	769,622	91.00
91.01	09101 SHORT STAY	0.000000	0	0	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.735336	922,993	0	0	678,710	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0.000000	0	0	0	0	95.00
200.00	Subtotal (see instructions)		38,879,632	3,985	13,114	10,605,909	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		38,879,632	3,985	13,114	10,605,909	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150059	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/23/2014 8:25 am
		Title XVIII	Hospital	PPS
Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00	05700 CT SCAN	0	0	57.00
57.01	03630 ULTRA SOUND	0	0	57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	29	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	775	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4	830	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	25	5,328	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03020 OTHER ANCILLARY	0	0	76.00
76.01	03021 CARDIAC REHAB	0	0	76.01
76.02	03022 WOMEN'S CENTER	0	0	76.02
76.03	03330 ENDOSCOPY	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	1	69	90.00
90.01	09001 OUTPATIENT	1	244	90.01
91.00	09100 EMERGENCY	0	0	91.00
91.01	09101 SHORT STAY	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0		95.00
200.00	Subtotal (see instructions)	806	6,500	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	806	6,500	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150059 Component CCN: 15T059		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part II Date/Time Prepared: 5/23/2014 8:25 am	
		Title XVIIII		Subprovider - IRF		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	1,342,960	44,060,446	0.030480	121,318	3,698	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	642,131	14,299,663	0.044905	96,171	4,319	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	317,249	6,739,168	0.047075	43,432	2,045	55.00
57.00	05700 CT SCAN	4,298	9,446,377	0.000455	61,800	28	57.00
57.01	03630 ULTRA SOUND	2,465	2,469,207	0.000998	8,435	8	57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2,991	3,404,012	0.000879	25,729	23	58.00
59.00	05900 CARDIAC CATHETERIZATION	140,087	11,417,565	0.012269	2,473	30	59.00
60.00	06000 LABORATORY	598,476	36,999,346	0.016175	704,988	11,403	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	161,129	1,623,733	0.099234	21,013	2,085	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	97,361	4,166,500	0.023368	370,730	8,663	65.00
66.00	06600 PHYSICAL THERAPY	91,901	18,167,099	0.005059	3,347,292	16,934	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	476,624	9,516,694	0.050083	58,117	2,911	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	283,662	46,935,170	0.006044	528,742	3,196	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	8,353	5,040,495	0.001657	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	334,514	19,533,427	0.017125	800,586	13,710	73.00
74.00	07400 RENAL DIALYSIS	24,217	347,405	0.069708	45,469	3,170	74.00
76.00	03020 OTHER ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03021 CARDIAC REHAB	9,364	1,976,467	0.004738	12,069	57	76.01
76.02	03022 WOMEN'S CENTER	357,100	3,642,839	0.098028	0	0	76.02
76.03	03330 ENDOSCOPY	121,669	6,192,791	0.019647	3,870	76	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	23,704	3,663,752	0.006470	0	0	90.00
90.01	09001 OUTPATIENT	8,807	1,535,960	0.005734	10,911	63	90.01
91.00	09100 EMERGENCY	775,670	20,787,725	0.037314	42,915	1,601	91.00
91.01	09101 SHORT STAY	0	0	0.000000	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	3,248,778	0.000000	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	5,824,732	275,214,619		6,306,060	74,020	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150059 Component CCN: 15T059	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/23/2014 8:25 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
57.01	03630 ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020 OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03021 CARDIAC REHAB	0	0	0	0	0	76.01
76.02	03022 WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330 ENDOSCOPY	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 OUTPATIENT	0	0	0	0	0	90.01
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
91.01	09101 SHORT STAY	0	0	0	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
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: 150059 Component CCN: 15T059	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/23/2014 8:25 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient Program Charges
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 + col. 7)	Ratio of Cost to Charges (col. 6 + col. 7)	
	6.00	7.00	8.00	9.00	10.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0	44,060,446	0.000000	0.000000	121,318 50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0 52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	14,299,663	0.000000	0.000000	96,171 54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	6,739,168	0.000000	0.000000	43,432 55.00
57.00 05700 CT SCAN	0	9,446,377	0.000000	0.000000	61,800 57.00
57.01 03630 ULTRA SOUND	0	2,469,207	0.000000	0.000000	8,435 57.01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	3,404,012	0.000000	0.000000	25,729 58.00
59.00 05900 CARDIAC CATHETERIZATION	0	11,417,565	0.000000	0.000000	2,473 59.00
60.00 06000 LABORATORY	0	36,999,346	0.000000	0.000000	704,988 60.00
60.01 06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0 60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	1,623,733	0.000000	0.000000	21,013 63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0 64.00
65.00 06500 RESPIRATORY THERAPY	0	4,166,500	0.000000	0.000000	370,730 65.00
66.00 06600 PHYSICAL THERAPY	0	18,167,099	0.000000	0.000000	3,347,292 66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0 67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0 68.00
69.00 06900 ELECTROCARDIOLOGY	0	9,516,694	0.000000	0.000000	58,117 69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	46,935,170	0.000000	0.000000	528,742 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	5,040,495	0.000000	0.000000	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	19,533,427	0.000000	0.000000	800,586 73.00
74.00 07400 RENAL DIALYSIS	0	347,405	0.000000	0.000000	45,469 74.00
76.00 03020 OTHER ANCILLARY	0	0	0.000000	0.000000	0 76.00
76.01 03021 CARDIAC REHAB	0	1,976,467	0.000000	0.000000	12,069 76.01
76.02 03022 WOMEN'S CENTER	0	3,642,839	0.000000	0.000000	0 76.02
76.03 03330 ENDOSCOPY	0	6,192,791	0.000000	0.000000	3,870 76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000 CLINIC	0	3,663,752	0.000000	0.000000	0 90.00
90.01 09001 OUTPATIENT	0	1,535,960	0.000000	0.000000	10,911 90.01
91.00 09100 EMERGENCY	0	20,787,725	0.000000	0.000000	42,915 91.00
91.01 09101 SHORT STAY	0	0	0.000000	0.000000	0 91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	3,248,778	0.000000	0.000000	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00 09500 AMBULANCE SERVICES					
200.00 Total (lines 50-199)	0	275,214,619			6,306,060 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150059	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/23/2014 8:25 am
	Component CCN: 15T059	Title XVIIII	Subprovider - IRF PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
57.00	05700 CT SCAN	0	0	0	57.00
57.01	03630 ULTRA SOUND	0	0	0	57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
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 PATIENT	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	03020 OTHER ANCILLARY	0	0	0	76.00
76.01	03021 CARDIAC REHAB	0	0	0	76.01
76.02	03022 WOMEN'S CENTER	0	0	0	76.02
76.03	03330 ENDOSCOPY	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0	0	0	90.00
90.01	09001 OUTPATIENT	0	0	0	90.01
91.00	09100 EMERGENCY	0	0	0	91.00
91.01	09101 SHORT STAY	0	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150059 Component CCN: 155669	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/23/2014 8:25 am
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
57.01	03630 ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020 OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03021 CARDIAC REHAB	0	0	0	0	0	76.01
76.02	03022 WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330 ENDOSCOPY	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 OUTPATIENT	0	0	0	0	0	90.01
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
91.01	09101 SHORT STAY	0	0	0	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
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: 150059 Component CCN: 155669	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/23/2014 8:25 am
		Title XVIII	Skilled Nursing Facility PPS

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	44,060,446	0.000000	0.000000	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	14,299,663	0.000000	0.000000	46,614	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	6,739,168	0.000000	0.000000	0	55.00
57.00 05700 CT SCAN	0	9,446,377	0.000000	0.000000	0	57.00
57.01 03630 ULTRA SOUND	0	2,469,207	0.000000	0.000000	0	57.01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	3,404,012	0.000000	0.000000	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	11,417,565	0.000000	0.000000	0	59.00
60.00 06000 LABORATORY	0	36,999,346	0.000000	0.000000	561,746	60.00
60.01 06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	1,623,733	0.000000	0.000000	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	4,166,500	0.000000	0.000000	172,109	65.00
66.00 06600 PHYSICAL THERAPY	0	18,167,099	0.000000	0.000000	1,561,607	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	9,516,694	0.000000	0.000000	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	46,935,170	0.000000	0.000000	41,076	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	5,040,495	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	19,533,427	0.000000	0.000000	635,475	73.00
74.00 07400 RENAL DIALYSIS	0	347,405	0.000000	0.000000	0	74.00
76.00 03020 OTHER ANCILLARY	0	0	0.000000	0.000000	0	76.00
76.01 03021 CARDIAC REHAB	0	1,976,467	0.000000	0.000000	7,004	76.01
76.02 03022 WOMEN'S CENTER	0	3,642,839	0.000000	0.000000	0	76.02
76.03 03330 ENDOSCOPY	0	6,192,791	0.000000	0.000000	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	3,663,752	0.000000	0.000000	0	90.00
90.01 09001 OUTPATIENT	0	1,535,960	0.000000	0.000000	0	90.01
91.00 09100 EMERGENCY	0	20,787,725	0.000000	0.000000	0	91.00
91.01 09101 SHORT STAY	0	0	0.000000	0.000000	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	3,248,778	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	275,214,619			3,025,631	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150059

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/23/2014 8:25 am

Component CCN: 155669

Title XVIII

Skilled Nursing  
Facility

PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
57.00	05700 CT SCAN	0	0	0	57.00
57.01	03630 ULTRA SOUND	0	0	0	57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
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 PATIENT	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	03020 OTHER ANCILLARY	0	0	0	76.00
76.01	03021 CARDIAC REHAB	0	0	0	76.01
76.02	03022 WOMEN'S CENTER	0	0	0	76.02
76.03	03330 ENDOSCOPY	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0	0	0	90.00
90.01	09001 OUTPATIENT	0	0	0	90.01
91.00	09100 EMERGENCY	0	0	0	91.00
91.01	09101 SHORT STAY	0	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/23/2014 8:25 am
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		15,152	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		15,152	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)		13,049	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)		5,035	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		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)		17,212,143	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)		17,212,143	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		17,212,143	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,135.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,719,609	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		5,719,609	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150059	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/23/2014 8:25 am		
Cost Center Description			Title XVIII		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	4,177,340	3,109	1,343.63	1,983	2,664,418	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)					13,067,202	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					21,451,229	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)					1,643,540	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					853,684	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,497,224	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					18,954,005	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)					2,103	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,135.97	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,388,945	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/23/2014 8:25 am	
		Title XVIII		Hospital		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,686,986	17,212,143	0.214208	2,388,945	511,731	90.00
91.00	Nursing School cost	0	17,212,143	0.000000	2,388,945	0	91.00
92.00	Allied health cost	0	17,212,143	0.000000	2,388,945	0	92.00
93.00	All other Medical Education	0	17,212,143	0.000000	2,388,945	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Component CCN: 15T059		Date/Time Prepared: 5/23/2014 8:25 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,108	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,108	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)		6,108	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		4,041	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,271,904	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,271,904	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,271,904	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		699.39	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,826,235	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)		2,826,235	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
		Component CCN: 15T059				Date/Time Prepared: 5/23/2014 8:25 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,271,081		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,097,316		49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					435,337		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					74,020		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					509,357		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,587,959		53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
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: 150059 Component CCN: 15T059		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/23/2014 8:25 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	657,993	4,271,904	0.154028	0	0	90.00
91.00	Nursing School cost	0	4,271,904	0.000000	0	0	91.00
92.00	Allied health cost	0	4,271,904	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,271,904	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059 Component CCN: 155669	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/23/2014 8:25 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,234	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,234	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,234	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		3,605	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,215,157	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,215,157	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,215,157	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1		
		Component CCN: 155669		Date/Time Prepared: 5/23/2014 8:25 am		
		Title XVIII	Skilled Nursing Facility	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)					48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					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)					50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					54.00
55.00	Target amount per discharge					55.00
56.00	Target amount (line 54 x line 55)					56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					57.00
58.00	Bonus payment (see instructions)					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					59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					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)					61.00
62.00	Relief payment (see instructions)					62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					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)					64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					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)					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)					68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					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)				3,215,157	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				614.28	71.00
72.00	Program routine service cost (line 9 x line 71)				2,214,479	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				2,214,479	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)				0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				0	80.00
81.00	Inpatient routine service cost per diem limitation				0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)				2,214,479	83.00
84.00	Program inpatient ancillary services (see instructions)				1,117,429	84.00
85.00	Utilization review - physician compensation (see instructions)				0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				3,331,908	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: 150059 Component CCN: 155669		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/23/2014 8:25 am	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XIX		Hospital
				Date/Time Prepared: 5/23/2014 8:25 am
Cost Center Description				Cost
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		15,152	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		15,152	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)		13,049	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)		884	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		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)		17,212,143	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)		17,212,143	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		17,212,143	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,135.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,004,197	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,004,197	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150059	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/23/2014 8:25 am	
Cost Center Description			Title XIX	Hospital	Cost	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,177,340	3,109	1,343.63	0	43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				1,386,308	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				2,390,505	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge				0.00	55.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00	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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)				2,103	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,135.97	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				2,388,945	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/23/2014 8:25 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Component CCN: 15T059		Date/Time Prepared: 5/23/2014 8:25 am
		Title XIX	Subprovider - IRF	Cost
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,108	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,108	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)		6,108	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)		173	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,271,904	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,271,904	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,271,904	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		699.39	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		120,994	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)		120,994	41.00

COMPUTATION OF INPATIENT OPERATING COST					Provider CCN: 150059	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
					Component CCN: 15T059		Date/Time Prepared: 5/23/2014 8:25 am
					Title XIX	Subprovider - IRF	Cost
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
<b>Cost Center Description</b>							
						1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						59,806	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						180,800	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
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: 150059 Component CCN: 15T059		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/23/2014 8:25 am	
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150059	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/23/2014 8:25 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		6,982,004	30.00
31.00	03100	INTENSIVE CARE UNIT		2,958,741	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.209452	11,497,192	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.280279	976,700	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.239072	90,524	55.00
57.00	05700	CT SCAN	0.034980	751,272	57.00
57.01	03630	ULTRA SOUND	0.089404	132,169	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.074296	164,744	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.134574	1,374,721	59.00
60.00	06000	LABORATORY	0.197465	5,082,977	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.567737	378,491	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.371403	1,813,654	65.00
66.00	06600	PHYSICAL THERAPY	0.360413	845,847	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.197433	1,051,438	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.385114	11,937,905	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.253765	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.548214	4,721,891	73.00
74.00	07400	RENAL DIALYSIS	0.766546	196,081	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	76.00
76.01	03021	CARDIAC REHAB	0.356798	91,494	76.01
76.02	03022	WOMEN'S CENTER	0.307521	1,052	76.02
76.03	03330	ENDOSCOPY	0.154620	99,249	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.502476	0	90.00
90.01	09001	OUTPATIENT	0.344724	57,363	90.01
91.00	09100	EMERGENCY	0.242875	1,314,573	91.00
91.01	09101	SHORT STAY	0.000000	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.735336	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		42,579,337	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)		42,579,337	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150059 Component CCN: 15T059	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/23/2014 8:25 am
		Title XVIIII	Subprovider - IRF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
41.00	04100 SUBPROVIDER - IRF		4,109,348	41.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.209452	121,318	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.280279	96,171	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.239072	43,432	55.00
57.00	05700 CT SCAN	0.034980	61,800	57.00
57.01	03630 ULTRA SOUND	0.089404	8,435	57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.074296	25,729	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.134574	2,473	59.00
60.00	06000 LABORATORY	0.197465	704,988	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.567737	21,013	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.371403	370,730	65.00
66.00	06600 PHYSICAL THERAPY	0.360413	3,347,292	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.197433	58,117	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.385114	528,742	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.253765	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.548214	800,586	73.00
74.00	07400 RENAL DIALYSIS	0.766546	45,469	74.00
76.00	03020 OTHER ANCILLARY	0.000000	0	76.00
76.01	03021 CARDIAC REHAB	0.356798	12,069	76.01
76.02	03022 WOMEN'S CENTER	0.307521	0	76.02
76.03	03330 ENDOSCOPY	0.154620	3,870	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.502476	0	90.00
90.01	09001 OUTPATIENT	0.344724	10,911	90.01
91.00	09100 EMERGENCY	0.242875	42,915	91.00
91.01	09101 SHORT STAY	0.000000	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.735336	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES			95.00
200.00	Total (sum of lines 50-94 and 96-98)		6,306,060	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)		6,306,060	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150059 Component CCN: 155669	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/23/2014 8:25 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
41.00	04100 SUBPROVIDER - IRF		70,983	41.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.209452	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.280279	46,614	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.239072	0	55.00
57.00	05700 CT SCAN	0.034980	0	57.00
57.01	03630 ULTRA SOUND	0.089404	0	57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.074296	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.134574	0	59.00
60.00	06000 LABORATORY	0.197465	561,746	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.567737	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.371403	172,109	65.00
66.00	06600 PHYSICAL THERAPY	0.360413	1,561,607	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.197433	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.385114	41,076	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.253765	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.548214	635,475	73.00
74.00	07400 RENAL DIALYSIS	0.766546	0	74.00
76.00	03020 OTHER ANCILLARY	0.000000	0	76.00
76.01	03021 CARDIAC REHAB	0.356798	7,004	76.01
76.02	03022 WOMEN'S CENTER	0.307521	0	76.02
76.03	03330 ENDOSCOPY	0.154620	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.502476	0	90.00
90.01	09001 OUTPATIENT	0.344724	0	90.01
91.00	09100 EMERGENCY	0.242875	0	91.00
91.01	09101 SHORT STAY	0.000000	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.735336	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES			95.00
200.00	Total (sum of lines 50-94 and 96-98)		3,025,631	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net Charges (line 200 minus line 201)		3,025,631	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150059	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/23/2014 8:25 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		1,061,126	30.00
31.00	03100	INTENSIVE CARE UNIT		334,737	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.209452	959,614	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.280279	84,622	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.239072	12,837	55.00
57.00	05700	CT SCAN	0.034980	67,159	57.00
57.01	03630	ULTRA SOUND	0.089404	15,858	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.074296	13,463	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.134574	131,251	59.00
60.00	06000	LABORATORY	0.197465	529,334	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.567737	35,628	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.371403	151,963	65.00
66.00	06600	PHYSICAL THERAPY	0.360413	56,698	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.197433	65,338	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.385114	1,229,445	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.253765	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.548214	694,530	73.00
74.00	07400	RENAL DIALYSIS	0.766546	12,772	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	76.00
76.01	03021	CARDIAC REHAB	0.356798	8,855	76.01
76.02	03022	WOMEN'S CENTER	0.307521	0	76.02
76.03	03330	ENDOSCOPY	0.154620	69,354	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.502476	0	90.00
90.01	09001	OUTPATIENT	0.344724	8,797	90.01
91.00	09100	EMERGENCY	0.242875	167,322	91.00
91.01	09101	SHORT STAY	0.000000	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.735336	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		4,314,840	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		4,314,840	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150059	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3	
		Component CCN: 15T059		Date/Time Prepared: 5/23/2014 8:25 am	
		Title XIX	Subprovider - IRF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
41.00	04100 SUBPROVIDER - IRF		72,198		41.00
43.00	04300 NURSERY		0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.209452	5,726	1,199	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.280279	1,125	315	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.239072	0	0	55.00
57.00	05700 CT SCAN	0.034980	69	2	57.00
57.01	03630 ULTRA SOUND	0.089404	0	0	57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.074296	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.134574	1,069	144	59.00
60.00	06000 LABORATORY	0.197465	78,547	15,510	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.567737	598	340	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.371403	16,537	6,142	65.00
66.00	06600 PHYSICAL THERAPY	0.360413	65,103	23,464	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.197433	1,328	262	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.385114	9,916	3,819	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.253765	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.548214	14,933	8,186	73.00
74.00	07400 RENAL DIALYSIS	0.766546	0	0	74.00
76.00	03020 OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03021 CARDIAC REHAB	0.356798	0	0	76.01
76.02	03022 WOMEN'S CENTER	0.307521	0	0	76.02
76.03	03330 ENDOSCOPY	0.154620	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.502476	0	0	90.00
90.01	09001 OUTPATIENT	0.344724	1,226	423	90.01
91.00	09100 EMERGENCY	0.242875	0	0	91.00
91.01	09101 SHORT STAY	0.000000	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.735336	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		196,177	59,806	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)		196,177		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150059	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/23/2014 8:25 am
		Title XVII	Hospital	PPS
		0	1.00	2.00
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER PPS</b>				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013 (see instructions)		10,370,981	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		3,893,091	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI (see instructions)		0	1.03
2.00	Outlier payments for discharges. (see instructions)		290,979	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		99.24	4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
29.00	Total IME payment ( sum of lines 22 and 28)		0	29.00
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.11	30.00
31.00	Percentage of Medicaid patient days (see instructions)		14.52	31.00
32.00	Sum of lines 30 and 31		16.63	32.00
33.00	Allowable disproportionate share percentage (see instructions)		3.56	33.00
34.00	Disproportionate share adjustment (see instructions)		403,856	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150059	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/23/2014 8:25 am	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1	On/After October 1	
			1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)			9,046,380,143	35.00
35.01	Factor 3 (see instructions)			0.000094264	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			852,745	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			214,939	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		214,939		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)			0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)			0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)			0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41)			0	46.00
47.00	Subtotal (see instructions)		15,173,846		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)			0	48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		15,173,846		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		1,241,498		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)			0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)			0	56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).			0	57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		16,415,344		59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		16,415,344		61.00
62.00	Deductibles billed to program beneficiaries		1,492,548		62.00
63.00	Coinurance billed to program beneficiaries		36,408		63.00
64.00	Allowable bad debts (see instructions)		174,247		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		113,261		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		81,564		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		14,999,649		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)			0	68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.92	Bundled Model 1 discount amount			0	70.92
70.93	HVBP incentive payment (see instructions)			-1,215	70.93
70.94	Hospital readmissions reduction adjustment (see instructions)			0	70.94
70.95	Recovery of Accelerated Depreciation			0	70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150059	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/23/2014 8:25 am	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	On/After October 1 2.00	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		14,998,434		71.00
71.01	Sequestration adjustment (see instructions)		226,476		71.01
72.00	Interim payments		14,934,095		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) line 71 minus lines 71.01, 72 and 73		-162,137		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		134,936		75.00
<b>TO BE COMPLETED BY CONTRACTOR</b>					
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the Time Value of Money		0.00		94.00
95.00	Time Value of Money for operating expenses(see instructions)		0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)		0		96.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150059

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

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
5/23/2014 8:25 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013	1.01	10,370,981	0	10,370,981	0	10,370,981	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013	1.02	3,893,091	0	0	3,893,091	3,893,091	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI	1.03	0	0	0	0	0	1.03
2.00	Outlier payments for discharges (see instructions)	2.00	290,979	0	257,275	33,705	290,980	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
<b>Indirect Medical Education Adjustment</b>								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>								
7.00	Amount from Worksheet E Part A, line 27 (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
<b>Disproportionate Share Adjustment</b>								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0356	0.0356	0.0356	0.0356		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	403,856	0	369,207	34,649	403,856	11.00
11.01	Uncompensated care payments	36.00	214,939	0	0	214,939	214,939	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	15,173,846	0	10,997,462	4,176,384	15,173,846	13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49.00	15,173,846	0	10,997,462	4,176,384	15,173,846	15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50.00	1,241,498	0	907,878	333,620	1,241,498	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	11,905,340	4,510,004	16,415,344	19.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150059

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

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
5/23/2014 8:25 am

		Title XVIII		Hospital		PPS		
	W/S L, line	(Amounts from L)						
	0	1.00	2.00	3.00	4.00	5.00		
20.00	Capital DRG other than outlier	1.00	1,134,758	0	823,576	311,182	1,134,758	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	67,818	0	56,054	11,764	67,818	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (line 20 times line 22)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0343	0.0343	0.0343	0.0343		24.00
25.00	Disproportionate share adjustment (line 20 times line 24)	11.00	38,922	0	28,248	10,674	38,922	25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	12.00	1,241,498	0	907,878	333,620	1,241,498	26.00
	W/S E, Part A line	(Amounts to E, Part A)						
	0	1.00	2.00	3.00	4.00	5.00		
27.00	Low volume adjustment factor			0.000000	0.000000			27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.96		0			0	28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to W/S E Part A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150059	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/23/2014 8:25 am
		Title XVII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		7,306	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		10,605,909	2.00
3.00	PPS payments		8,927,517	3.00
4.00	Outlier payment (see instructions)		36,262	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		7,306	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		17,099	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)		17,099	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		17,099	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		9,793	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)		7,306	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)		8,963,779	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
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)		2,025,220	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)		6,945,865	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		6,945,865	30.00
31.00	Primary payer payments		1,142	31.00
32.00	Subtotal (line 30 minus line 31)		6,944,723	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		267,265	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		173,722	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		157,413	36.00
37.00	Subtotal (see instructions)		7,118,445	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-57	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)		7,118,502	40.00
40.01	Sequestration adjustment (see instructions)		107,489	40.01
41.00	Interim payments		6,923,149	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		87,864	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150059

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/23/2014 8:25 am

Title XVIII

Hospital

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		14,833,271		6,834,285	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	07/03/2013	100,824	07/03/2013	88,864	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)		100,824		88,864	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)		14,934,095		6,923,149	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		87,864	6.01
6.02	SETTLEMENT TO PROGRAM		162,137		0	6.02
7.00	Total Medicare program liability (see instructions)		14,771,958		7,011,013	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150059  
Component CCN: 15T059

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/23/2014 8:25 am

Title XVIII

Subprovider -  
IRF

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					0 1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		5,325,070			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)					0 3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0			0 3.01
3.02			0			0 3.02
3.03			0			0 3.03
3.04			0			0 3.04
3.05			0			0 3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0			0 3.50
3.51			0			0 3.51
3.52			0			0 3.52
3.53			0			0 3.53
3.54			0			0 3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0			0 3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5,325,070			0 4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					0 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)					0 6.00
6.01	SETTLEMENT TO PROVIDER		93,112			0 6.01
6.02	SETTLEMENT TO PROGRAM		0			0 6.02
7.00	Total Medicare program liability (see instructions)		5,418,182			0 7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					0 8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150059  
Component CCN: 155669

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/23/2014 8:25 am

Title XVIII

Skilled Nursing  
Facility

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,703,266		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)		1,703,266		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		442		0	6.02
7.00	Total Medicare program liability (see instructions)		1,702,824		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 150059

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

Worksheet E-1  
Part II  
Date/Time Prepared:  
5/23/2014 8:25 am

		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			3,827 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			7,018 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			1,183 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			16,158 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			311,797,968 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			4,556,266 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			1,306,088 8.00
9.00	Sequestration adjustment amount (see instructions)			0 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			1,306,088 10.00
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			1,354,511 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			-48,423 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150059 Component CCN: 15T059	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part III Date/Time Prepared: 5/23/2014 8:25 am
		Title XVIIII	Subprovider - IRF	PPS
		Prior to 10/01	On/After 10/01	
		1.00	1.01	
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)	3,896,159	1,412,889	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0757		2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	193,249	47,897	3.00
4.00	Outlier Payments	74,470		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)	0.00		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.)	0.00		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)	0.00		9.00
10.00	Average Daily Census (see instructions)	16.734247		10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	0	12.00
13.00	Total PPS Payment (see instructions)	5,624,664		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)	5,624,664		17.00
18.00	Primary payer payments	0		18.00
19.00	Subtotal (line 17 less line 18).	5,624,664		19.00
20.00	Deductibles	85,220		20.00
21.00	Subtotal (line 19 minus line 20)	5,539,444		21.00
22.00	Coinurance	40,848		22.00
23.00	Subtotal (line 21 minus line 22)	5,498,596		23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	4,085		24.00
25.00	Adjusted reimbursable bad debts (see instructions)	2,655		25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		26.00
27.00	Subtotal (sum of lines 23 and 25)	5,501,251		27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0		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)	5,501,251		32.00
32.01	Sequestration adjustment (see instructions)	83,069		32.01
33.00	Interim payments	5,325,070		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	93,112		35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	101,852		36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4	74,470		50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0		51.00
52.00	The rate used to calculate the Time Value of Money	0.00		52.00
53.00	Time Value of Money (see instructions)	0		53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150059 Component CCN: 155669	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part VI Date/Time Prepared: 5/23/2014 8:25 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		1,831,347	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		1,831,347	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		102,416	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)		1,728,931	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14)		1,728,931	15.00
15.01	Sequestration adjustment (see instructions)		26,107	15.01
16.00	Interim payments		1,703,266	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program line 15 minus 15.01, 16 and 17		-442	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2		0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150059	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part VII Date/Time Prepared: 5/23/2014 8:25 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		2,390,505		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		2,390,505	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		2,390,505	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		1,395,863		8.00
9.00	Ancillary service charges		4,314,840	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		5,710,703	0	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		5,710,703	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		3,320,198	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		2,390,505	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		2,390,505	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		2,390,505	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		2,390,505	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		2,390,505	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		2,390,505	0	40.00
41.00	Interim payments		2,167,544	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		222,961	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150059 Component CCN: 15T059	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part VII Date/Time Prepared: 5/23/2014 8:25 am
		Title XIX	Subprovider - IRF	Cost
		Inpatient 1.00	Outpatient 2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>				
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient hospital/SNF/NF services	180,800		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	180,800	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	180,800	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable Charges</b>				
8.00	Routine service charges	72,198		8.00
9.00	Ancillary service charges	196,177	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	268,375	0	12.00
<b>CUSTOMARY CHARGES</b>				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	268,375	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	87,575	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	180,800	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	180,800	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	180,800	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	180,800	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	180,800	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	180,800	0	40.00
41.00	Interim payments	169,631	0	41.00
42.00	Balance due provider/program (line 40 minus 41)	11,169	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	0	43.00

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

Provider CCN: 150059

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

Worksheet G

Date/Time Prepared:  
5/23/2014 8:25 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	35,336,135	0	0	0	1.00
2.00	Temporary investments	3,492,308	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	43,833,626	0	0	0	4.00
5.00	Other receivable	558,062	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	3,328,480	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	16,083,384	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)	102,631,995	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	9,814,610	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	216,652,188	0	0	0	15.00
16.00	Accumulated depreciation	-129,777,934	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	96,688,864	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	64,459,184	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	2,187,671	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	66,646,855	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	265,967,714	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	16,091,745	0	0	0	37.00
38.00	Salaries, wages, and fees payable	6,888,972	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	40,925,747	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	63,906,464	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	39,485,323	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	39,485,323	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	103,391,787	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	162,575,927	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	162,575,927	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	265,967,714	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150059

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

Worksheet G-1

Date/Time Prepared:  
5/23/2014 8:25 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		152,910,605		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		9,665,322				2.00
3.00	Total (sum of line 1 and line 2)		162,575,927		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		162,575,927		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		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)		162,575,927		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150059

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/23/2014 8:25 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	21,873,622		21,873,622	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	6,016,014		6,016,014	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	2,554,338		2,554,338	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)	30,443,974		30,443,974	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	6,139,375		6,139,375	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)	6,139,375		6,139,375	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	36,583,349		36,583,349	17.00
18.00	Ancillary services	98,699,983	147,278,421	245,978,404	18.00
19.00	Outpatient services	3,274,673	25,961,542	29,236,215	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	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN OFFICES	55,003	46,498,068	46,553,071	27.00
27.01	PHYSICIAN PROFESSIONAL FEES	0	3,534,877	3,534,877	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	138,613,008	223,272,908	361,885,916	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		160,030,302		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	PHYS. BILLING FEES RECORDED AS INCOM	25,678			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)		25,678		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		160,004,624		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150059

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

Worksheet G-3

Date/Time Prepared:  
5/23/2014 8:25 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	361,885,916	1.00
2.00	Less contractual allowances and discounts on patients' accounts	208,275,556	2.00
3.00	Net patient revenues (line 1 minus line 2)	153,610,360	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	160,004,624	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-6,394,264	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	9,927,342	24.00
24.01	INVESTMENT GAIN (LOSS)	5,656,508	24.01
24.02	CONTRIBUTIONS AND OTHER NONOPERATING	475,736	24.02
25.00	Total other income (sum of lines 6-24)	16,059,586	25.00
26.00	Total (line 5 plus line 25)	9,665,322	26.00
27.00		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)	9,665,322	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150059	Period: From 01/01/2013 To 12/31/2013	Worksheet L Parts I-III Date/Time Prepared: 5/23/2014 8:25 am
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		1,134,758	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		67,818	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		44.27	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		2.11	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		14.52	8.00
9.00	Sum of lines 7 and 8		16.63	9.00
10.00	Allowable disproportionate share percentage (see instructions)		3.43	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		38,922	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		1,241,498	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00