

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: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet 5 Parts I-III Date/Time Prepared: 5/29/2014 9:02 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/29/2014 Time: 9:02 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 WITHAM MEMORIAL HOSPITAL (150104) for the cost reporting period beginning 01/01/2013 and ending 12/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 5/29/2014 Time: 9:02 am
SUZec6nAICvJrcfStYC8dSP5apy6P0
rd7b50xA40:elQzp:Vz2tPZZ6CKQDC
txmQ1nzFBH0gyarB
PI: Date: 5/29/2014 Time: 9:02 am
oH5eq5szQhr0qtNQY2ELaz11ekfdQ0
xd31i0z14042PCIJstQKr9LtsDxfnJ
tf5d09rcOq0T6w66

(Signed) George Poyas
Officer or Administrator of Provider(s)
SRP / CFO / Treasurer
Title
Date 05/30/2014

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	30,399	33,215	5,100	-361,668	1.00
2.00 Subprovider - IPF	0	-141	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
200.00 Total	0	30,258	33,215	5,100	-361,668	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.

1.00		2.00		3.00		4.00							
Hospital and Hospital Health Care Complex Address:													
1.00	Street: 2605 N. LEBANON STREET			PO Box:						1.00			
2.00	City: LEBANON			State: IN		Zip Code: 46052-		County: BOONE		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			
								V	XVIII	XIX			
Hospital and Hospital-Based Component Identification:													
3.00	Hospital		WI THAM MEMORIAL HOSPITAL	150104	26900	1	07/01/1966	N	P	O	3.00		
4.00	Subprovider - IPF		WI THAM HOSPITAL GEROPSYCH	15S104	26900	4	01/01/2000	N	P	N	4.00		
5.00	Subprovider - IRF										5.00		
6.00	Subprovider - (Other)										6.00		
7.00	Swing Beds - SNF										7.00		
8.00	Swing Beds - NF										8.00		
9.00	Hospital-Based SNF										9.00		
10.00	Hospital-Based NF										10.00		
11.00	Hospital-Based OLTC										11.00		
12.00	Hospital-Based HHA										12.00		
13.00	Separately Certified ASC										13.00		
14.00	Hospital-Based Hospice										14.00		
15.00	Hospital-Based Health Clinic - RHC										15.00		
16.00	Hospital-Based Health Clinic - FQHC										16.00		
17.00	Hospital-Based (CMHC) I										17.00		
18.00	Renal Dialysis										18.00		
19.00	Other										19.00		
							From:	To:					
							1.00	2.00					
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2013	12/31/2013		20.00			
21.00	Type of Control (see instructions)						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.						528	510	0	0	898	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.						0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/29/2014 8:52 am		
		Urban/Rural S	Date of Geogr			
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0			35.00	
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	Y		39.00	
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/29/2014 8:52 am		
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y		70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			N	0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	76.00
					1.00	
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
				V	XIX	
				1.00	2.00	
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	95.00

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		V 1.00	XIX 2.00			
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column. Rural Providers	0.00	0.00		97.00	
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N			105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	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 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2			118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	293,890	0	0		118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N			118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y			121.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00

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		1.00	2.00			
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00
		1.00	2.00	3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00
142.00	Street:	PO Box:				142.00
143.00	City:	State:		Zip Code:		143.00
				1.00		
144.00	Are provider based physicians' costs included in Worksheet A?	Y				144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N				145.00
				1.00		2.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N				147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N				149.00
		Part A		Part B		Title V
		1.00		2.00		3.00
						Title XIX
						4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
						1.00
Multi campus						
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N				165.00
		Name	County	State	Zip Code	CBSA
		0	1.00	2.00	3.00	4.00
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				168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.75				169.00
				Beginning		Ending
				1.00		2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2012		09/30/2013		170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/29/2014 8:52 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
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/21/2014	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/29/2014 8:52 am
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	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.	0	1.00	2.00	3.00	21.00
		N			N	
					1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)						
Capital Related Cost						
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions					22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					27.00
Interest Expense						
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.					28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.00
Purchased Services						
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.					32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
Provider-Based Physicians						
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.					34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.					35.00
			Y/N	Date		
			1.00	2.00		
Home Office Costs						
36.00	Were home office costs claimed on the cost report?					36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
			1.00	2.00		
Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TINA		SEVERS		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946		TSEVERS@BLUEANDCO.COM		43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	04/21/2014	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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

HFS Supplemental Information		Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part IX Date/Time Prepared: 5/29/2014 8:52 am
		Title V 1.00	Title XIX 2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient 1.00	Outpatient 2.00	
CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V 1.00	Title XIX 2.00	
RCE DISALLOWANCE				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150104

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2014 8:52 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					Ti tle 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	60	21,900	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)		60	21,900	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,920	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)		68	24,820	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	10	3,650		0	16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		78				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title 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)	2,210	492	4,896			1.00
2.00 HMO and other (see instructions)	520	1,392				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	2,210	492	4,896			7.00
8.00 INTENSIVE CARE UNIT	590	0	1,502			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	921			13.00
14.00 Total (see instructions)	2,800	492	7,319	0.00	572.09	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	1,874	0	2,075	0.00	20.20	16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	592.29	27.00
28.00 Observation Bed Days		311	1,392			28.00
29.00 Ambulance Trips	1,502					29.00
30.00 Employee discount days (see instruction)			85			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	52	74			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: 150104

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2014 8:52 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	816	172	2,134	1.00
2.00 HMO and other (see instructions)			144			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	816	172	2,134	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	191	0	224	16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00 SUBPROVIDER	0.00	0	0	0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 150104		Period: From 01/01/2013 To 12/31/2013		Worksheet S-3 Part II Date/Time Prepared: 5/29/2014 8:52 am	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	39,244,309	0	39,244,309	1,159,986.00	33.83	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		13,733,605	111,747	13,845,352	356,385.00	38.85	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor (see instructions)		522,901	0	522,901	10,661.00	49.05	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		8,429,116	0	8,429,116			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		3,840,713	0	3,840,713			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	853,976	-628,866	225,110	8,745.00	25.74	26.00
27.00	Administrative & General	5.00	8,198,962	257,922	8,456,884	173,537.00	48.73	27.00
28.00	Administrative & General under contract (see inst.)		951,941	0	951,941	20,884.00	45.58	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	515,474	12,247	527,721	21,526.00	24.52	30.00
31.00	Laundry & Linen Service	8.00	21,126	720	21,846	2,095.00	10.43	31.00
32.00	Housekeeping	9.00	309,898	10,162	320,060	25,982.00	12.32	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	558,689	-300,262	258,427	14,844.00	17.41	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	314,058	314,058	23,177.00	13.55	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	447,897	8,169	456,066	12,033.00	37.90	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	393,550	5,218	398,768	12,143.00	32.84	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150104

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

Worksheet S-3
Part II
Date/Time Prepared:
5/29/2014 8:52 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
41.00	Medical Records & Medical Records Library	16.00	792,670	21,282	813,952	36,235.00	22.46	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150104

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

Worksheet S-3
Part III
Date/Time Prepared:
5/29/2014 8:52 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	40,196,250	0	40,196,250	1,180,870.00	34.04	1.00
2.00	Excluded area salaries (see instructions)	13,733,605	111,747	13,845,352	356,385.00	38.85	2.00
3.00	Subtotal salaries (line 1 minus line 2)	26,462,645	-111,747	26,350,898	824,485.00	31.96	3.00
4.00	Subtotal other wages & related costs (see inst.)	522,901	0	522,901	10,661.00	49.05	4.00
5.00	Subtotal wage-related costs (see inst.)	8,429,116	0	8,429,116	0.00	31.99	5.00
6.00	Total (sum of lines 3 thru 5)	35,414,662	-111,747	35,302,915	835,146.00	42.27	6.00
7.00	Total overhead cost (see instructions)	13,044,183	-299,350	12,744,833	351,201.00	36.29	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet S-3 Part IV Date/Time Prepared: 5/29/2014 8:52 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			1,332,746 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
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			7,533,600 8.00
9.00	Prescription Drug Plan			211,499 9.00
10.00	Dental, Hearing and Vision Plan			260,954 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			67,928 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)			139,281 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			335,914 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			0 16.00
TAXES				
17.00	FICA-Employers Portion Only			2,335,634 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			52,273 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			0 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			0 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			12,269,829 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS			65,420 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet S-3 Part V Date/Time Prepared: 5/29/2014 8:52 am
Cost Center Description			Contract Labor	Benefit Cost
PART V - Contract Labor and Benefit Cost			1.00	2.00
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		0	0 1.00
2.00	Hospital		0	0 2.00
3.00	Subprovider - IPF		0	0 3.00
4.00	Subprovider - IRF		0	0 4.00
5.00	Subprovider - (Other)		0	0 5.00
6.00	Swing Beds - SNF		0	0 6.00
7.00	Swing Beds - NF		0	0 7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			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			17.00
18.00	Other		0	0 18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet S-10 Date/Time Prepared: 5/29/2014 8:52 am
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.252659	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		5,801,871	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		29,864,473	6.00	
7.00	Medicaid cost (line 1 times line 6)		7,545,528	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		1,743,657	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)		1,743,657	19.00	
			1.00		
			1.00		
			2.00		
			3.00		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	5,762,415	0	5,762,415	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,455,926	0	1,455,926	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,455,926	0	1,455,926	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?				24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		15,149,909	15,149,909	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		167,040	167,040	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		14,982,869	14,982,869	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		3,785,557	3,785,557	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		5,241,483	5,241,483	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		6,985,140	6,985,140	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150104

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

Worksheet A
Date/Time Prepared:
5/29/2014 8:52 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		6,779,133	6,779,133	109,570	6,888,703	1.00
2.00	00200		0	0	3,376,201	3,376,201	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	853,976	10,111,356	10,965,332	-421,422	10,543,910	4.00
5.00	00500	8,198,962	8,945,347	17,144,309	-1,410,929	15,733,380	5.00
7.00	00700	515,474	2,804,670	3,320,144	-33,038	3,287,106	7.00
8.00	00800	21,126	191,995	213,121	720	213,841	8.00
9.00	00900	309,898	158,969	468,867	7,345	476,212	9.00
10.00	01000	558,689	625,629	1,184,318	-695,905	488,413	10.00
11.00	01100	0	0	0	705,954	705,954	11.00
13.00	01300	447,897	41,504	489,401	7,426	496,827	13.00
15.00	01500	393,550	1,795,355	2,188,905	-628,147	1,560,758	15.00
16.00	01600	792,670	312,436	1,105,106	-45,065	1,060,041	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,661,831	1,635,730	4,297,561	-93,824	4,203,737	30.00
31.00	03100	914,500	217,652	1,132,152	-40,853	1,091,299	31.00
40.00	04000	982,479	186,239	1,168,718	10,641	1,179,359	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	41,800	41,800	0	41,800	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,676,105	4,313,003	5,989,108	-3,533,067	2,456,041	50.00
54.00	05400	947,427	2,362,308	3,309,735	-188,405	3,121,330	54.00
55.00	05500	0	0	0	0	0	55.00
55.01	05501	233,114	189,570	422,684	-76,887	345,797	55.01
57.00	05700	130,191	1,043,628	1,173,819	-522,737	651,082	57.00
58.00	05800	257,306	1,026,310	1,283,616	-440,423	843,193	58.00
59.00	05900	162,220	391,634	553,854	-171,582	382,272	59.00
60.00	06000	1,791,052	2,914,058	4,705,110	-39,816	4,665,294	60.00
63.00	06300	0	167,121	167,121	0	167,121	63.00
64.00	06400	0	0	0	0	0	64.00
66.00	06600	916,025	194,807	1,110,832	-1,177	1,109,655	66.00
67.00	06700	310,458	180,350	490,808	6,780	497,588	67.00
67.01	06701	129,779	177,461	307,240	-14,913	292,327	67.01
68.00	06800	58,274	6,363	64,637	897	65,534	68.00
69.00	06900	0	0	0	0	0	69.00
69.01	06901	704,838	165,464	870,302	-32,070	838,232	69.01
71.00	07100	0	-547	-547	1,542,128	1,541,581	71.00
72.00	07200	0	0	0	2,401,818	2,401,818	72.00
73.00	07300	0	0	0	598,289	598,289	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	153,519	127,796	281,315	-5,177	276,138	90.01
90.02	09002	0	0	0	0	0	90.02
90.03	09003	0	1,284	1,284	0	1,284	90.03
90.04	09004	0	99	99	0	99	90.04
90.05	09005	0	2,755	2,755	-653	2,102	90.05
90.07	09007	0	2,971	2,971	-1,304	1,667	90.07
90.09	09009	24,651	7,498	32,149	1,441	33,590	90.09
90.11	09011	0	4,744	4,744	-3,323	1,421	90.11
90.12	09012	0	55,014	55,014	-41,955	13,059	90.12
90.13	09013	121,822	46,818	168,640	604	169,244	90.13
90.14	09014	197,484	227,602	425,086	-9,696	415,390	90.14
91.00	09100	2,027,866	2,321,537	4,349,403	-182,521	4,166,882	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	1,223,011	363,417	1,586,428	-102,527	1,483,901	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		27,716,194	50,140,880	77,857,074	32,398	77,889,472	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	11,498,282	3,939,574	15,437,856	-33,118	15,404,738	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	29,833	112,551	142,384	720	143,104	194.02
200.00		39,244,309	54,193,005	93,437,314	0	93,437,314	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150104

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

Worksheet A
Date/Time Prepared:
5/29/2014 8:52 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-169,349	6,719,354	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	0	3,376,201	2.00
3.00	00300 OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-2,973,972	7,569,938	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-55,924	15,677,456	5.00
7.00	00700 OPERATION OF PLANT	-824,227	2,462,879	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	213,841	8.00
9.00	00900 HOUSEKEEPING	0	476,212	9.00
10.00	01000 DIETARY	-90,314	398,099	10.00
11.00	01100 CAFETERIA	-188,646	517,308	11.00
13.00	01300 NURSING ADMINISTRATION	0	496,827	13.00
15.00	01500 PHARMACY	0	1,560,758	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-1,881	1,058,160	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-833,000	3,370,737	30.00
31.00	03100 INTENSIVE CARE UNIT	0	1,091,299	31.00
40.00	04000 SUBPROVIDER - I/PF	-33,150	1,146,209	40.00
41.00	04100 SUBPROVIDER - I/RF	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	42.00
43.00	04300 NURSERY	0	41,800	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	2,456,041	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	-60	3,121,270	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
55.01	05501 ULTRA SOUND	0	345,797	55.01
57.00	05700 CT SCAN	0	651,082	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	843,193	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	382,272	59.00
60.00	06000 LABORATORY	-251,000	4,414,294	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	167,121	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
66.00	06600 PHYSICAL THERAPY	0	1,109,655	66.00
67.00	06700 OCCUPATIONAL THERAPY	-8,844	488,744	67.00
67.01	06701 AUDIOLOGY	-184,048	108,279	67.01
68.00	06800 SPEECH PATHOLOGY	0	65,534	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
69.01	06901 CARDIOLOGY	0	838,232	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-105,145	1,436,436	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	2,401,818	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	-25,530	572,759	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	-19,717	256,421	90.01
90.02	09002 CLINIC	0	0	90.02
90.03	09003 DERMATOLOGY CLINIC	-1,284	0	90.03
90.04	09004 ENT CLINIC	0	99	90.04
90.05	09005 SURGERY CLINIC	-2,102	0	90.05
90.07	09007 UROLOGY CLINIC	-1,667	0	90.07
90.09	09009 GASTROENTEROLOGY CLINIC	-24,000	9,590	90.09
90.11	09011 NEUROLOGY CLINIC	-1,421	0	90.11
90.12	09012 OPHTHALMOLOGY CLINIC	0	13,059	90.12
90.13	09013 ALLERGY CLINIC	0	169,244	90.13
90.14	09014 WOUND CARE	0	415,390	90.14
91.00	09100 EMERGENCY	-1,451,697	2,715,185	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	-542	1,483,359	95.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	-7,247,520	70,641,952	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	15,404,738	192.00
194.00	07950 THORNTOWN OFFICE BUILDING	0	0	194.00
194.01	07951 CAFE/BOUTIQUE	0	0	194.01
194.02	07952 OTHER NONREIMBURSABLE COST CENTERS	0	143,104	194.02
200.00	TOTAL (SUM OF LINES 118-199)	-7,247,520	86,189,794	200.00

COST CENTERS USED IN COST REPORT		Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet Non-CMS W Date/Time Prepared: 5/29/2014 8:52 am
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Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
	1.00	2.00	
GENERAL SERVICE COST CENTERS			
1.00 NEW CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00 OTHER CAPITAL RELATED COSTS	00300		3.00
4.00 EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00 ADMINISTRATIVE & GENERAL	00500		5.00
7.00 OPERATION OF PLANT	00700		7.00
8.00 LAUNDRY & LINEN SERVICE	00800		8.00
9.00 HOUSEKEEPING	00900		9.00
10.00 DIETARY	01000		10.00
11.00 CAFETERIA	01100		11.00
13.00 NURSING ADMINISTRATION	01300		13.00
15.00 PHARMACY	01500		15.00
16.00 MEDICAL RECORDS & LIBRARY	01600		16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS	03000		30.00
31.00 INTENSIVE CARE UNIT	03100		31.00
40.00 SUBPROVIDER - IPF	04000		40.00
41.00 SUBPROVIDER - IRF	04100		41.00
42.00 SUBPROVIDER	04200		42.00
43.00 NURSERY	04300		43.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	05000		50.00
54.00 RADIOLOGY-DIAGNOSTIC	05400		54.00
55.00 RADIOLOGY-THERAPEUTIC	05500		55.00
55.01 ULTRA SOUND	05501		55.01
57.00 CT SCAN	05700		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
59.00 CARDIAC CATHETERIZATION	05900		59.00
60.00 LABORATORY	06000		60.00
63.00 BLOOD STORING, PROCESSING & TRANS.	06300		63.00
64.00 INTRAVENOUS THERAPY	06400		64.00
66.00 PHYSICAL THERAPY	06600		66.00
67.00 OCCUPATIONAL THERAPY	06700		67.00
67.01 AUDIOLOGY	06701		67.01
68.00 SPEECH PATHOLOGY	06800		68.00
69.00 ELECTROCARDIOLOGY	06900		69.00
69.01 CARDIOLOGY	06901		69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	07200		72.00
73.00 DRUGS CHARGED TO PATIENTS	07300		73.00
OUTPATIENT SERVICE COST CENTERS			
90.00 CLINIC	09000		90.00
90.01 OTHER OUTPATIENT SERVICE COST CENTER	09001		90.01
90.02 CLINIC	09002		90.02
90.03 DERMATOLOGY CLINIC	09003		90.03
90.04 ENT CLINIC	09004		90.04
90.05 SURGERY CLINIC	09005		90.05
90.07 UROLOGY CLINIC	09007		90.07
90.09 GASTROENTEROLOGY CLINIC	09009		90.09
90.11 NEUROLOGY CLINIC	09011		90.11
90.12 OPHTHAMOLOGY CLINIC	09012		90.12
90.13 ALLERGY CLINIC	09013		90.13
90.14 WOUND CARE	09014		90.14
91.00 EMERGENCY	09100		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
OTHER REIMBURSABLE COST CENTERS			
95.00 AMBULANCE SERVICES	09500		95.00
SPECIAL PURPOSE COST CENTERS			
118.00 SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS			
190.00 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	19000		190.00
192.00 PHYSICIANS' PRIVATE OFFICES	19200		192.00
194.00 THORNTOWN OFFICE BUILDING	07950		194.00
194.01 CAFE/BOUTIQUE	07951		194.01
194.02 OTHER NONREIMBURSABLE COST CENTERS	07952		194.02
200.00 TOTAL (SUM OF LINES 118-199)			200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS	4.00	0	209,273	1.00
	TOTALS		0	209,273	
B - INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	45,264	1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	307,882	2.00
	TOTALS		0	353,146	
C - CAFETERIA					
1.00	CAFETERIA	11.00	314,058	391,896	1.00
	TOTALS		314,058	391,896	
D - MME DEPRECIATION					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	3,376,201	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
	TOTALS		0	3,376,201	
E - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	624,414	1.00
	TOTALS		0	624,414	
F - MED SUPPLY IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	2,401,818	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	TOTALS		0	2,401,818	
G - CHARGABLE MED SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,592,635	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00

RECLASSIFICATIONS

Provider CCN: 150104

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

Worksheet A-6

Date/Time Prepared:
5/29/2014 8:52 am

						Increases					
Cost Center		Line #	Salary	Other							
2.00		3.00	4.00	5.00							
10.00		0.00	0	0						10.00	
11.00		0.00	0	0						11.00	
12.00		0.00	0	0						12.00	
13.00		0.00	0	0						13.00	
14.00		0.00	0	0						14.00	
15.00		0.00	0	0						15.00	
16.00		0.00	0	0						16.00	
17.00		0.00	0	0						17.00	
18.00		0.00	0	0						18.00	
19.00		0.00	0	0						19.00	
20.00		0.00	0	0						20.00	
21.00		0.00	0	0						21.00	
TOTALS			0	1,592,635							
H - BONUS RECLASSIFICATION											
1.00	EMPLOYEE BENEFITS	4.00	6,844	0						1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	257,922	0						2.00	
3.00	OPERATION OF PLANT	7.00	12,247	0						3.00	
4.00	LAUNDRY & LINEN SERVICE	8.00	720	0						4.00	
5.00	HOUSEKEEPING	9.00	10,162	0						5.00	
6.00	DIETARY	10.00	13,796	0						6.00	
7.00	NURSING ADMINISTRATION	13.00	8,169	0						7.00	
8.00	PHARMACY	15.00	5,218	0						8.00	
9.00	MEDICAL RECORDS & LIBRARY	16.00	21,282	0						9.00	
10.00	ADULTS & PEDIATRICS	30.00	29,380	0						10.00	
11.00	INTENSIVE CARE UNIT	31.00	11,358	0						11.00	
12.00	SUBPROVIDER - IPF	40.00	16,482	0						12.00	
13.00	OPERATING ROOM	50.00	22,966	0						13.00	
14.00	RADIOLOGY-DIAGNOSTIC	54.00	20,650	0						14.00	
15.00	ULTRA SOUND	55.01	2,905	0						15.00	
16.00	CT SCAN	57.00	1,081	0						16.00	
17.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	3,122	0						17.00	
18.00	CARDIAC CATHETERIZATION	59.00	1,681	0						18.00	
19.00	LABORATORY	60.00	29,397	0						19.00	
20.00	PHYSICAL THERAPY	66.00	11,864	0						20.00	
21.00	OCCUPATIONAL THERAPY	67.00	9,754	0						21.00	
22.00	AUDIOLOGY	67.01	2,129	0						22.00	
23.00	SPEECH PATHOLOGY	68.00	961	0						23.00	
24.00	CARDIOLOGY	69.01	7,473	0						24.00	
25.00	OTHER OUTPATIENT SERVICE CENTER	90.01	4,563	0						25.00	
26.00	GASTROENTEROLOGY CLINIC	90.09	1,441	0						26.00	
27.00	ALLERGY CLINIC	90.13	1,441	0						27.00	
28.00	WOUND CARE	90.14	5,523	0						28.00	
29.00	EMERGENCY	91.00	19,914	0						29.00	
30.00	AMBULANCE SERVICES	95.00	18,213	0						30.00	
31.00	PHYSICIANS' PRIVATE OFFICES	192.00	76,332	0						31.00	
32.00	OTHER NONREIMBURSABLE COST CENTERS	194.02	720	0						32.00	
TOTALS			635,710	0							
500.00	Grand Total: Increases		949,768	8,949,383						500.00	

RECLASSIFICATIONS

Provider CCN: 150104

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

Worksheet A-6
Date/Time Prepared:
5/29/2014 8:52 am

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	209,273	0	1.00
	TOTALS		0	209,273		
B - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	353,146	12	1.00
2.00		0.00	0	0	12	2.00
	TOTALS		0	353,146		
C - CAFETERIA						
1.00	DIETARY	10.00	314,058	391,896	0	1.00
	TOTALS		314,058	391,896		
D - MME DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	243,576	9	1.00
2.00	EMPLOYEE BENEFITS	4.00	0	1,829	0	2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	1,106,432	0	3.00
4.00	OPERATION OF PLANT	7.00	0	45,285	0	4.00
5.00	HOUSEKEEPING	9.00	0	2,817	0	5.00
6.00	DIETARY	10.00	0	3,747	0	6.00
7.00	NURSING ADMINISTRATION	13.00	0	743	0	7.00
8.00	PHARMACY	15.00	0	3,051	0	8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	66,347	0	9.00
10.00	ADULTS & PEDIATRICS	30.00	0	29,992	0	10.00
11.00	INTENSIVE CARE UNIT	31.00	0	2,274	0	11.00
12.00	SUBPROVIDER - IPF	40.00	0	2,074	0	12.00
13.00	OPERATING ROOM	50.00	0	183,757	0	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	187,700	0	14.00
15.00	ULTRA SOUND	55.01	0	77,589	0	15.00
16.00	CT SCAN	57.00	0	519,406	0	16.00
17.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	441,485	0	17.00
18.00	CARDIAC CATHETERIZATION	59.00	0	21,424	0	18.00
19.00	LABORATORY	60.00	0	68,800	0	19.00
20.00	PHYSICAL THERAPY	66.00	0	12,135	0	20.00
21.00	OCCUPATIONAL THERAPY	67.00	0	2,204	0	21.00
22.00	AUDIOLOGY	67.01	0	17,042	0	22.00
23.00	SPEECH PATHOLOGY	68.00	0	64	0	23.00
24.00	CARDIOLOGY	69.01	0	38,714	0	24.00
25.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	694	0	25.00
26.00	OTHER OUTPATIENT SERVICE COST CENTER	90.01	0	7,794	0	26.00
27.00	SURGERY CLINIC	90.05	0	653	0	27.00
28.00	UROLOGY CLINIC	90.07	0	1,195	0	28.00
29.00	NEUROLOGY CLINIC	90.11	0	3,323	0	29.00
30.00	OPHTHAMOLOGY CLINIC	90.12	0	41,955	0	30.00
31.00	ALLERGY CLINIC	90.13	0	804	0	31.00
32.00	WOUND CARE	90.14	0	1,208	0	32.00
33.00	EMERGENCY	91.00	0	17,962	0	33.00
34.00	AMBULANCE SERVICES	95.00	0	112,676	0	34.00
35.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	109,450	0	35.00
	TOTALS		0	3,376,201		
E - DRUGS						
1.00	PHARMACY	15.00	0	624,414	0	1.00
	TOTALS		0	624,414		
F - MED SUPPLY IMPLANTS						
1.00	ADULTS & PEDIATRICS	30.00	0	928	0	1.00
2.00	OPERATING ROOM	50.00	0	2,195,623	0	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	21,010	0	3.00
4.00	CARDIAC CATHETERIZATION	59.00	0	147,788	0	4.00
5.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	7,341	0	5.00
6.00	DRUGS CHARGED TO PATIENTS	73.00	0	26,125	0	6.00
7.00	WOUND CARE	90.14	0	3,003	0	7.00
	TOTALS		0	2,401,818		
G - CHARGABLE MED SUPPLIES						
1.00	PHARMACY	15.00	0	5,900	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	92,284	0	2.00
3.00	INTENSIVE CARE UNIT	31.00	0	49,937	0	3.00
4.00	SUBPROVIDER - IPF	40.00	0	3,767	0	4.00
5.00	OPERATING ROOM	50.00	0	1,176,653	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	345	0	6.00
7.00	ULTRA SOUND	55.01	0	2,203	0	7.00
8.00	CT SCAN	57.00	0	4,412	0	8.00

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	2,060	0	9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	4,051	0	10.00
11.00	LABORATORY	60.00	0	413	0	11.00
12.00	PHYSICAL THERAPY	66.00	0	906	0	12.00
13.00	OCCUPATIONAL THERAPY	67.00	0	770	0	13.00
14.00	CARDIOLOGY	69.01	0	829	0	14.00
15.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	42,472	0	15.00
16.00	OTHER OUTPATIENT SERVICE COST CENTER	90.01	0	1,946	0	16.00
17.00	UROLOGY CLINIC	90.07	0	109	0	17.00
18.00	ALLERGY CLINIC	90.13	0	33	0	18.00
19.00	WOUND CARE	90.14	0	11,008	0	19.00
20.00	EMERGENCY	91.00	0	184,473	0	20.00
21.00	AMBULANCE SERVICES	95.00	0	8,064	0	21.00
	TOTALS		0	1,592,635		
H - BONUS RECLASSIFICATION						
1.00	EMPLOYEE BENEFITS	4.00	635,710	0	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
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
16.00		0.00	0	0	0	16.00
17.00		0.00	0	0	0	17.00
18.00		0.00	0	0	0	18.00
19.00		0.00	0	0	0	19.00
20.00		0.00	0	0	0	20.00
21.00		0.00	0	0	0	21.00
22.00		0.00	0	0	0	22.00
23.00		0.00	0	0	0	23.00
24.00		0.00	0	0	0	24.00
25.00		0.00	0	0	0	25.00
26.00		0.00	0	0	0	26.00
27.00		0.00	0	0	0	27.00
28.00		0.00	0	0	0	28.00
29.00		0.00	0	0	0	29.00
30.00		0.00	0	0	0	30.00
31.00		0.00	0	0	0	31.00
32.00		0.00	0	0	0	32.00
	TOTALS		635,710	0		
500.00	Grand Total: Decreases		949,768	8,949,383		500.00

Increases			Decreases			
Cost Center	Line #	Salary	Cost Center	Line #	Salary	
2.00	3.00	4.00	6.00	7.00	8.00	
A - EMPLOYEE BENEFITS						
1.00	EMPLOYEE BENEFITS	4.00	ADMINISTRATIVE & GENERAL	5.00	0	1.00
	TOTALS		TOTALS		0	
B - INSURANCE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	ADMINISTRATIVE & GENERAL	5.00	0	1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00		0.00	0	2.00
	TOTALS		TOTALS		0	
C - CAFETERIA						
1.00	CAFETERIA	11.00	DIETARY	10.00	314,058	1.00
	TOTALS		TOTALS		314,058	
D - MME DEPRECIATION						
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00		0.00	EMPLOYEE BENEFITS	4.00	0	2.00
3.00		0.00	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00		0.00	OPERATION OF PLANT	7.00	0	4.00
5.00		0.00	HOUSEKEEPING	9.00	0	5.00
6.00		0.00	DIETARY	10.00	0	6.00
7.00		0.00	NURSING ADMINISTRATION	13.00	0	7.00
8.00		0.00	PHARMACY	15.00	0	8.00
9.00		0.00	MEDICAL RECORDS & LIBRARY	16.00	0	9.00
10.00		0.00	ADULTS & PEDIATRICS	30.00	0	10.00
11.00		0.00	INTENSIVE CARE UNIT	31.00	0	11.00
12.00		0.00	SUBPROVIDER - IPF	40.00	0	12.00
13.00		0.00	OPERATING ROOM	50.00	0	13.00
14.00		0.00	RADIOLOGY-DIAGNOSTIC	54.00	0	14.00
15.00		0.00	ULTRA SOUND	55.01	0	15.00
16.00		0.00	CT SCAN	57.00	0	16.00
17.00		0.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	17.00
18.00		0.00	CARDIAC CATHETERIZATION	59.00	0	18.00
19.00		0.00	LABORATORY	60.00	0	19.00
20.00		0.00	PHYSICAL THERAPY	66.00	0	20.00
21.00		0.00	OCCUPATIONAL THERAPY	67.00	0	21.00
22.00		0.00	AUDIOLOGY	67.01	0	22.00
23.00		0.00	SPEECH PATHOLOGY	68.00	0	23.00
24.00		0.00	CARDIOLOGY	69.01	0	24.00
25.00		0.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	25.00
26.00		0.00	OTHER OUTPATIENT SERVICE COST CENTER	90.01	0	26.00
27.00		0.00	SURGERY CLINIC	90.05	0	27.00
28.00		0.00	UROLOGY CLINIC	90.07	0	28.00
29.00		0.00	NEUROLOGY CLINIC	90.11	0	29.00
30.00		0.00	OPHTHAMOLOGY CLINIC	90.12	0	30.00
31.00		0.00	ALLERGY CLINIC	90.13	0	31.00
32.00		0.00	WOUND CARE	90.14	0	32.00
33.00		0.00	EMERGENCY	91.00	0	33.00
34.00		0.00	AMBULANCE SERVICES	95.00	0	34.00
35.00		0.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	35.00
	TOTALS		TOTALS		0	
E - DRUGS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	PHARMACY	15.00	0	1.00
	TOTALS		TOTALS		0	
F - MED SUPPLY IMPLANTS						
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	ADULTS & PEDIATRICS	30.00	0	1.00
2.00		0.00	OPERATING ROOM	50.00	0	2.00
3.00		0.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3.00
4.00		0.00	CARDIAC CATHETERIZATION	59.00	0	4.00
5.00		0.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	5.00
6.00		0.00	DRUGS CHARGED TO PATIENTS	73.00	0	6.00
7.00		0.00	WOUND CARE	90.14	0	7.00
	TOTALS		TOTALS		0	
G - CHARGABLE MED SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	PHARMACY	15.00	0	1.00
2.00		0.00	ADULTS & PEDIATRICS	30.00	0	2.00
3.00		0.00	INTENSIVE CARE UNIT	31.00	0	3.00
4.00		0.00	SUBPROVIDER - IPF	40.00	0	4.00
5.00		0.00	OPERATING ROOM	50.00	0	5.00

RECLASSIFICATIONS

Provider CCN: 150104

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

Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
5/29/2014 8:52 am

Increases				Decreases					
Cost Center	Line #	Salary		Cost Center	Line #	Salary			
2.00	3.00	4.00		6.00	7.00	8.00			
6.00	0.00			0	RADIOLOGY-DIAGNOSTIC	54.00	0	6.00	
7.00	0.00			0	ULTRASOUND	55.01	0	7.00	
8.00	0.00			0	CT SCAN	57.00	0	8.00	
9.00	0.00			0	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	9.00	
10.00	0.00			0	CARDIAC CATHETERIZATION	59.00	0	10.00	
11.00	0.00			0	LABORATORY	60.00	0	11.00	
12.00	0.00			0	PHYSICAL THERAPY	66.00	0	12.00	
13.00	0.00			0	OCCUPATIONAL THERAPY	67.00	0	13.00	
14.00	0.00			0	CARDIOLOGY	69.01	0	14.00	
15.00	0.00			0	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	15.00	
16.00	0.00			0	OTHER OUTPATIENT SERVICE COST CENTER	90.01	0	16.00	
17.00	0.00			0	UROLOGY CLINIC	90.07	0	17.00	
18.00	0.00			0	ALLERGY CLINIC	90.13	0	18.00	
19.00	0.00			0	WOUND CARE	90.14	0	19.00	
20.00	0.00			0	EMERGENCY	91.00	0	20.00	
21.00	0.00			0	AMBULANCE SERVICES	95.00	0	21.00	
TOTALS				TOTALS				0	
H - BONUS RECLASSIFICATION									
1.00	4.00	6,844		4.00	EMPLOYEE BENEFITS	635,710	1.00		
2.00	5.00	257,922		0.00			2.00		
3.00	7.00	12,247		0.00			3.00		
4.00	8.00	720		0.00			4.00		
5.00	9.00	10,162		0.00			5.00		
6.00	10.00	13,796		0.00			6.00		
7.00	13.00	8,169		0.00			7.00		
8.00	15.00	5,218		0.00			8.00		
9.00	16.00	21,282		0.00			9.00		
10.00	30.00	29,380		0.00			10.00		
11.00	31.00	11,358		0.00			11.00		
12.00	40.00	16,482		0.00			12.00		
13.00	50.00	22,966		0.00			13.00		
14.00	54.00	20,650		0.00			14.00		
15.00	55.01	2,905		0.00			15.00		
16.00	57.00	1,081		0.00			16.00		
17.00	58.00	3,122		0.00			17.00		
18.00	59.00	1,681		0.00			18.00		
19.00	60.00	29,397		0.00			19.00		
20.00	66.00	11,864		0.00			20.00		
21.00	67.00	9,754		0.00			21.00		
22.00	67.01	2,129		0.00			22.00		
23.00	68.00	961		0.00			23.00		
24.00	69.01	7,473		0.00			24.00		
25.00	90.01	4,563		0.00			25.00		
26.00	90.09	1,441		0.00			26.00		
27.00	90.13	1,441		0.00			27.00		
28.00	90.14	5,523		0.00			28.00		
29.00	91.00	19,914		0.00			29.00		
30.00	95.00	18,213		0.00			30.00		
31.00	192.00	76,332		0.00			31.00		
32.00	194.02	720		0.00			32.00		
CENTERS									
TOTALS				TOTALS				635,710	
500.00	Grand Total: Increases		949,768	Grand Total: Decreases		949,768	500.00		

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150104

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

Worksheet A-7
Part I
Date/Time Prepared:
5/29/2014 8:52 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	7,269,626	452,093	0	452,093	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	78,943,761	587,558	0	587,558	1,301	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	39,545,615	2,352,230	0	2,352,230	140,462	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	125,759,002	3,391,881	0	3,391,881	141,763	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	125,759,002	3,391,881	0	3,391,881	141,763	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	7,721,719	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	79,530,018	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	41,757,383	0				5.00
6.00	Movable Equipment	0	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	129,009,120	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	129,009,120	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150104

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

Worksheet A-7
Part II
Date/Time Prepared:
5/29/2014 8:52 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	6,779,133	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	6,779,133	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	6,779,133				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	6,779,133				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150104

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

Worksheet A-7
Part III
Date/Time Prepared:
5/29/2014 8:52 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	79,530,018	0	79,530,018	0.655715	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	41,757,383	0	41,757,383	0.344285	0	2.00
3.00	Total (sum of lines 1-2)	121,287,401	0	121,287,401	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	6,535,557	-64,452	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	3,376,201	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	9,911,758	-64,452	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	-104,897	353,146	0	0	6,719,354	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	3,376,201	2.00
3.00	Total (sum of lines 1-2)	-104,897	353,146	0	0	10,095,555	3.00

Provider CCN: 150104

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

Worksheet A-8
Date/Time Prepared:
5/29/2014 8:52 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)		0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-5,105	ADMINISTRATIVE & GENERAL	5.00		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	-2,577,691				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00		0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0				0	12.00
13.00 Laundry and linen service		0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-188,646	CAFETERIA	11.00		0	14.00
15.00 Rental of quarters to employees and others		0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00		0	16.00
17.00 Sale of drugs to other than patients		0		0.00		0	17.00
18.00 Sale of medical records and abstracts	B	-1,881	MEDICAL RECORDS & LIBRARY	16.00		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00		0	19.00
20.00 Vending machines	B	-5,975	DIETARY	10.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	OPHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			ONEW CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			ONEW CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant		0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)			OADULTS & PEDIATRICS	30.00			30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 150104

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

Worksheet A-8

Date/Time Prepared:
5/29/2014 8:52 am

31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		68.00	31.00			
				Basis/Code (2)	Amount			Cost Center	Line #	Wkst. A-7 Ref.
					SPEECH PATHOLOGY					
32.00	CAH HIT Adjustment for Depreciation and Interest		0			0.00	0 32.00			
33.00	HOSPITAL ADMINISTRATIVE SPONSORSHIPS/DO	A	-59,910		ADMINISTRATIVE & GENERAL	5.00	0 33.00			
33.01			0			0.00	0 33.01			
33.02	LEASE INCOME	B	-27,222		NEW CAP REL COSTS-BLDG & FIXT	1.00	10 33.02			
33.03	RENTAL REVENUE	B	-27,030		NEW CAP REL COSTS-BLDG & FIXT	1.00	10 33.03			
33.04	MEDICAL STAFF FEES	B	-1,200		ADMINISTRATIVE & GENERAL	5.00	0 33.04			
33.05			0			0.00	0 33.05			
33.06	EMPLOYEE RECORD FEES	B	-44		ADMINISTRATIVE & GENERAL	5.00	0 33.06			
33.07	PATIENT ACCOUNTS	B	-87,138		ADMINISTRATIVE & GENERAL	5.00	0 33.07			
33.08			0			0.00	0 33.08			
33.09			0			0.00	0 33.09			
33.10	MEALS ON WHEELS	B	-49,192		DIETARY	10.00	0 33.10			
33.11	DIETARY TAX REVENUE	B	-8,525		DIETARY	10.00	0 33.11			
33.12			0			0.00	0 33.12			
33.13			0			0.00	0 33.13			
33.14			0			0.00	0 33.14			
33.15	RADIOLOGY DIAGNOSTIC - ANSON	B	-60		RADIOLOGY-DIAGNOSTIC	54.00	0 33.15			
33.16			0			0.00	0 33.16			
33.17	DERMATOLOGY CLINIC RENT	A	-1,284		DERMATOLOGY CLINIC	90.03	0 33.17			
33.18			0			0.00	0 33.18			
33.19	SURGERY CLINIC RENT	A	-2,102		SURGERY CLINIC	90.05	0 33.19			
33.20			0			0.00	0 33.20			
33.21	UROLOGY CLINIC RENT	A	-1,667		UROLOGY CLINIC	90.07	0 33.21			
33.22	GASTROENTEROLOGY CLINIC RENT	A	-24,000		GASTROENTEROLOGY CLINIC	90.09	0 33.22			
33.23	NEUROLOGY CLINIC RENT	A	-1,421		NEUROLOGY CLINIC	90.11	0 33.23			
33.24	AMBULANCE	B	-542		AMBULANCE SERVICES	95.00	0 33.24			
33.25	RENTAL INCOME ANSON	B	-824,227		OPERATION OF PLANT	7.00	0 33.25			
33.26	2005 PREMIUM AMORTIZATION	B	-134,258		NEW CAP REL COSTS-BLDG & FIXT	1.00	11 33.26			
33.27	2010 PREMIUM AMORTIZATION	B	-24,133		NEW CAP REL COSTS-BLDG & FIXT	1.00	11 33.27			
33.28	2005 BOND GAIN/LOSS ON INVESTMENT	B	46,875		NEW CAP REL COSTS-BLDG & FIXT	1.00	11 33.28			
33.29	2005 BOND INTEREST ON INVEST	B	-35,251		NEW CAP REL COSTS-BLDG & FIXT	1.00	11 33.29			
33.30	2010 BOND INTEREST ON INVEST	B	-8,419		NEW CAP REL COSTS-BLDG & FIXT	1.00	11 33.30			
33.31	INTEREST INCOME - UNNECESSARY BORROW	B	-288,842		NEW CAP REL COSTS-BLDG & FIXT	1.00	11 33.31			
33.32	LOSS ON INVESTMENT	B	339,131		NEW CAP REL COSTS-BLDG & FIXT	1.00	11 33.32			
33.33	GAIN/(LOSS) SHOVN	B	536,704		ADMINISTRATIVE & GENERAL	5.00	0 33.33			
33.34	GAIN/(LOSS) CHA	B	-70,722		ADMINISTRATIVE & GENERAL	5.00	0 33.34			
33.35	GAIN/(LOSS) SHORRG	B	217,031		ADMINISTRATIVE & GENERAL	5.00	0 33.35			
33.36			0			0.00	0 33.36			
33.37			0			0.00	0 33.37			
33.38	HEARING AID COSTS	A	-184,048		AUDIOLOGY	67.01	0 33.38			
33.39	PHYSICIAN RECRUITMENT	A	-19,724		ADMINISTRATIVE & GENERAL	5.00	0 33.39			
33.40	BANK FEES	A	-134,457		ADMINISTRATIVE & GENERAL	5.00	0 33.40			
33.41	LOBBYING EXPENSE-IHHA DUES	A	-1,512		ADMINISTRATIVE & GENERAL	5.00	0 33.41			
33.42	LOBBYING EXPENSE-AHA DUES	A	-4,116		ADMINISTRATIVE & GENERAL	5.00	0 33.42			
33.43	NON-REIMBURSABLE ADVERTISING COSTS	A	-414,749		ADMINISTRATIVE & GENERAL	5.00	0 33.43			
33.44	PHYSICIAN CLINIC ANSON	B	-19,717		OTHER OUTPATIENT SERVICE COST CENTER	90.01	0 33.44			
33.45			0			0.00	0 33.45			
33.46	CENTRAL SUPPLY PURCHASING DISCOUNTS	B	-105,145		MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0 33.46			
33.47			0			0.00	0 33.47			
33.48			0			0.00	0 33.48			

Provider CCN: 150104

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

Worksheet A-8

Date/Time Prepared:
 5/29/2014 8:52 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00
33.49 PHARMACY ED	B	-25,530	DRUGS CHARGED TO PATIENTS	73.00	0	33.49
33.50 HEAD START	B	-26,622	DIETARY	10.00	0	33.50
33.51		0		0.00	0	33.51
33.52 WELLNESS REVENUE	B	-49,476	EMPLOYEE BENEFITS	4.00	0	33.52
33.53 OTHER OPERATING REVENUE	B	-10,982	ADMINISTRATIVE & GENERAL	5.00	0	33.53
33.54 1208 N LEBANON RENTAL INCOME	B	-10,200	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.54
33.55 SELF INSURANCE COST OFFSET	A	-2,924,496	EMPLOYEE BENEFITS	4.00	0	33.55
33.56		0		0.00	0	33.56
33.57		0		0.00	0	33.57
33.58		0		0.00	0	33.58
33.59		0		0.00	0	33.59
33.60		0		0.00	0	33.60
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,247,520				50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150104

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

Worksheet A-8-2

Date/Time Prepared:
5/29/2014 8:52 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	30.00	ADULTS & PEDIATRICS	833,000	833,000	0	0	0	1.00
2.00	40.00	SUBPROVIDER - IPF	67,526	0	67,526	154,100	464	2.00
3.00	60.00	LABORATORY	251,000	251,000	0	0	0	3.00
4.00	67.00	OCCUPATIONAL THERAPY	8,844	8,844	0	0	0	4.00
5.00	91.00	EMERGENCY	1,451,697	1,451,697	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,612,067	2,544,541	67,526		464	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	40.00	SUBPROVIDER - IPF	34,376	1,719	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			34,376	1,719	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	833,000		1.00
2.00	40.00	SUBPROVIDER - IPF	0	34,376	33,150	33,150		2.00
3.00	60.00	LABORATORY	0	0	0	251,000		3.00
4.00	67.00	OCCUPATIONAL THERAPY	0	0	0	8,844		4.00
5.00	91.00	EMERGENCY	0	0	0	1,451,697		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		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	34,376	33,150	2,577,691		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150104

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

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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	6,719,354	6,719,354				1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	3,376,201		3,376,201			2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	7,569,938	15,282	7,678	7,592,898		4.00
5.00 00500 ADMINISTRATIVE & GENERAL	15,677,456	488,380	245,391	1,645,659	18,056,886	5.00
7.00 00700 OPERATION OF PLANT	2,462,879	639,831	321,489	102,691	3,526,890	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	213,841	0	0	4,251	218,092	8.00
9.00 00900 HOUSEKEEPING	476,212	73,677	37,020	62,282	649,191	9.00
10.00 01000 DIETARY	398,099	164,920	82,866	50,288	696,173	10.00
11.00 01100 CAFETERIA	517,308	0	0	61,114	578,422	11.00
13.00 01300 NURSING ADMINISTRATION	496,827	0	0	88,748	585,575	13.00
15.00 01500 PHARMACY	1,560,758	50,912	25,581	77,598	1,714,849	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	1,058,160	80,425	40,410	158,390	1,337,385	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	3,370,737	534,934	268,783	523,694	4,698,148	30.00
31.00 03100 INTENSIVE CARE UNIT	1,091,299	146,908	73,815	180,166	1,492,188	31.00
40.00 04000 SUBPROVIDER - IPF	1,146,209	168,202	84,515	194,392	1,593,318	40.00
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300 NURSERY	41,800	0	0	0	41,800	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	2,456,041	426,939	214,519	330,629	3,428,128	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	3,121,270	522,147	262,358	188,382	4,094,157	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01 05501 ULTRA SOUND	345,797	0	0	45,928	391,725	55.01
57.00 05700 CT SCAN	651,082	0	0	25,545	676,627	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	843,193	44,794	22,507	50,678	961,172	58.00
59.00 05900 CARDIAC CATHETERIZATION	382,272	37,758	18,972	31,894	470,896	59.00
60.00 06000 LABORATORY	4,414,294	243,508	122,353	354,248	5,134,403	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	167,121	0	0	0	167,121	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00 06600 PHYSICAL THERAPY	1,109,655	235,683	118,421	180,562	1,644,321	66.00
67.00 06700 OCCUPATIONAL THERAPY	488,744	0	0	62,311	551,055	67.00
67.01 06701 AUDIOLOGY	108,279	0	0	25,669	133,948	67.01
68.00 06800 SPEECH PATHOLOGY	65,534	0	0	11,527	77,061	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01 06901 CARDIOLOGY	838,232	24,288	12,204	138,611	1,013,335	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,436,436	0	0	0	1,436,436	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2,401,818	0	0	0	2,401,818	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	572,759	0	0	0	572,759	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER	256,421	100,354	50,424	30,762	437,961	90.01
90.02 09002 CLINIC	0	161,349	81,071	0	242,420	90.02
90.03 09003 DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04 09004 ENT CLINIC	99	0	0	0	99	90.04
90.05 09005 SURGERY CLINIC	0	0	0	0	0	90.05
90.07 09007 UROLOGY CLINIC	0	0	0	0	0	90.07
90.09 09009 GASTROENTEROLOGY CLINIC	9,590	0	0	5,077	14,667	90.09
90.11 09011 NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12 09012 OPHTHALMOLOGY CLINIC	13,059	0	0	0	13,059	90.12
90.13 09013 ALLERGY CLINIC	169,244	0	0	23,986	193,230	90.13
90.14 09014 WOUND CARE	415,390	92,005	46,229	39,504	593,128	90.14
91.00 09100 EMERGENCY	2,715,185	645,030	324,101	398,486	4,082,802	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	1,483,359	124,983	62,799	241,535	1,912,676	95.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	70,641,952	5,022,309	2,523,506	5,334,607	65,833,921	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	16,384	8,232	0	24,616	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	15,404,738	1,093,554	549,465	2,252,346	19,300,103	192.00
194.00 07950 THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01 07951 CAFE/BOUTIQUE	0	47,683	23,959	0	71,642	194.01
194.02 07952 OTHER NONREIMBURSABLE COST CENTERS	143,104	539,424	271,039	5,945	959,512	194.02
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	86,189,794	6,719,354	3,376,201	7,592,898	86,189,794	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150104

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

Worksheet B
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,056,886				5.00
7.00	00700	OPERATION OF PLANT	934,710	4,461,600			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	57,800		275,892		8.00
9.00	00900	HOUSEKEEPING	172,051	68,109	0	889,351	9.00
10.00	01000	DIETARY	184,503	152,456	0	55,143	1,088,275
11.00	01100	CAFETERIA	153,296	0	0	18,385	0
13.00	01300	NURSING ADMINISTRATION	155,191	0	0	8,313	0
15.00	01500	PHARMACY	454,476	47,064	0	16,786	0
16.00	01600	MEDICAL RECORDS & LIBRARY	354,439	74,347	0	36,770	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,245,122	494,504	15,544	279,334	635,022
31.00	03100	INTENSIVE CARE UNIT	395,466	135,805	3,795	74,180	190,917
40.00	04000	SUBPROVIDER - IPF	422,268	155,490	2,377	88,211	262,336
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	11,078	0	1,295	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	908,536	394,671	41,740	16,467	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,085,050	482,683	22,340	74,500	0
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
55.01	05501	ULTRA SOUND	103,817	0	7,463	4,796	0
57.00	05700	CT SCAN	179,322	0	29,887	7,354	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	254,734	41,409	13,111	7,034	0
59.00	05900	CARDIAC CATHETERIZATION	124,799	34,904	3,833	0	0
60.00	06000	LABORATORY	1,360,740	225,103	49,108	31,495	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	44,291	0	1,081	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	3,068	0	0
66.00	06600	PHYSICAL THERAPY	435,785	217,870	5,748	11,351	0
67.00	06700	OCCUPATIONAL THERAPY	146,043	0	1,138	5,436	0
67.01	06701	AUDIOLOGY	35,499	0	910	3,997	0
68.00	06800	SPEECH PATHOLOGY	20,423	0	399	2,398	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
69.01	06901	CARDIOLOGY	268,558	22,452	10,630	24,141	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	380,690	0	4,577	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	636,539	0	6,345	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	151,795	0	12,821	17,426	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	116,070	92,769	0	42,845	0
90.02	09002	CLINIC	64,247	149,154	0	62,989	0
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0
90.04	09004	ENT CLINIC	26	0	0	0	0
90.05	09005	SURGERY CLINIC	0	0	0	0	0
90.07	09007	UROLOGY CLINIC	0	0	155	0	0
90.09	09009	GASTROENTEROLOGY CLINIC	3,887	0	0	0	0
90.11	09011	NEUROLOGY CLINIC	0	0	596	0	0
90.12	09012	OPHTHALMOLOGY CLINIC	3,461	0	147	0	0
90.13	09013	ALLERGY CLINIC	51,211	0	1,993	0	0
90.14	09014	WOUND CARE	157,193	85,051	2,396	0	0
91.00	09100	EMERGENCY	1,082,041	596,278	27,514	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	506,905	42,720	5,881	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,662,062	3,512,839	275,892	889,351	1,088,275
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	6,524	15,146	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,115,019	889,536	0	0	0
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0
194.01	07951	CAFE/BOUTIQUE	18,987	44,079	0	0	0
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	254,294	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	18,056,886	4,461,600	275,892	889,351	1,088,275

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part I Date/Time Prepared: 5/29/2014 8:52 am		
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal
		11.00	13.00	15.00	16.00	24.00
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100	750,103				11.00
13.00	01300	14,513	763,592			13.00
15.00	01500	29,026	0	2,262,201		15.00
16.00	01600	58,817	0	0	1,861,758	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	197,837	178,577	4,832	457,512	8,206,432
31.00	03100	16,041	54,308	1,238	95,126	2,459,064
40.00	04000	25,207	83,821	184	113,246	2,746,458
41.00	04100	0	0	0	0	0
42.00	04200	0	0	0	0	0
43.00	04300	0	0	0	0	54,173
ANCILLARY SERVICE COST CENTERS						
50.00	05000	17,569	130,015	52,508	164,206	5,153,840
54.00	05400	21,388	0	1,830	439,393	6,221,341
55.00	05500	0	0	0	0	0
55.01	05501	2,292	0	1,948	47,563	559,604
57.00	05700	3,055	0	3,133	54,358	953,736
58.00	05800	7,639	0	19,142	29,444	1,333,685
59.00	05900	0	10,589	978	0	645,999
60.00	06000	62,636	0	564	45,298	6,909,347
63.00	06300	0	0	0	0	212,493
64.00	06400	0	0	0	0	3,068
66.00	06600	31,318	53,138	1,045	88,332	2,488,908
67.00	06700	12,985	17,859	41,437	38,504	814,457
67.01	06701	13,749	10,902	0	0	199,005
68.00	06800	14,513	3,316	0	0	118,110
69.00	06900	0	0	0	0	0
69.01	06901	31,318	47,729	1,029	84,934	1,504,126
71.00	07100	16,041	0	0	0	1,837,744
72.00	07200	0	0	0	0	3,044,702
73.00	07300	0	0	0	0	754,801
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	0	0	0	0	0
90.01	09001	25,971	12,287	422	190,253	918,578
90.02	09002	0	0	0	0	518,810
90.03	09003	0	0	0	0	0
90.04	09004	0	0	0	0	125
90.05	09005	0	0	153	0	153
90.07	09007	0	0	2,236	0	2,391
90.09	09009	0	10,948	0	0	29,502
90.11	09011	0	0	7	0	603
90.12	09012	0	0	453	0	17,120
90.13	09013	0	6,858	3,539	0	256,831
90.14	09014	48,887	15,235	9,629	0	911,519
91.00	09100	0	123,185	145,600	0	6,057,420
92.00	09200	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	99,301	0	22,053	0	2,589,536
SPECIAL PURPOSE COST CENTERS						
118.00		750,103	758,767	313,960	1,848,169	57,523,681
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0	0	46,286
192.00	19200	0	4,427	1,948,241	13,589	27,270,915
194.00	07950	0	0	0	0	0
194.01	07951	0	0	0	0	134,708
194.02	07952	0	398	0	0	1,214,204
200.00		0	0	0	0	0
201.00		0	0	0	0	0
202.00		750,103	763,592	2,262,201	1,861,758	86,189,794

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150104

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

Worksheet B
Part I
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
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
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - I/PF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
55.01	05501	ULTRA SOUND	0	55.01
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
67.01	06701	AUDIOLOGY	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
69.01	06901	CARDIOLOGY	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	90.01
90.02	09002	CLINIC	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	90.03
90.04	09004	ENT CLINIC	0	90.04
90.05	09005	SURGERY CLINIC	0	90.05
90.07	09007	UROLOGY CLINIC	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	90.11
90.12	09012	OPHTHAMOLOGY CLINIC	0	90.12
90.13	09013	ALLERGY CLINIC	0	90.13
90.14	09014	WOUND CARE	0	90.14
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	95.00
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	194.02
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118-201)	0	202.00

COST ALLOCATION STATISTICS

Provider CCN: 150104

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

Worksheet Non-CMS W
Date/Time Prepared:
5/29/2014 8:52 am

Cost Center Description		Statistics Code	Statistics Description		
		1.00	2.00		
GENERAL SERVICE COST CENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE	FEET	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	3	SQUARE	FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS	SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-34	ACCUM.	COST	5.00
7.00	OPERATION OF PLANT	33	SQUARE	FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	C	GROSS	CHARGES	8.00
9.00	HOUSEKEEPING	9	HOURS OF	SERVICE	9.00
10.00	DIETARY	10	MEALS	SERVED	10.00
11.00	CAFETERIA	11	MEALS	SERVED	11.00
13.00	NURSING ADMINISTRATION	13	DIRECT	NRSING HRS	13.00
15.00	PHARMACY	15	COSTED	REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	16	TIME	SPENT	16.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 5/29/2014 8:52 am	
Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	15,282	7,678	22,960
5.00	00500	ADMINISTRATIVE & GENERAL	0	488,380	245,391	733,771
7.00	00700	OPERATION OF PLANT	0	639,831	321,489	961,320
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0
9.00	00900	HOUSEKEEPING	0	73,677	37,020	110,697
10.00	01000	DIETARY	0	164,920	82,866	247,786
11.00	01100	CAFETERIA	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	0	0	0
15.00	01500	PHARMACY	0	50,912	25,581	76,493
16.00	01600	MEDICAL RECORDS & LIBRARY	0	80,425	40,410	120,835
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	534,934	268,783	803,717
31.00	03100	INTENSIVE CARE UNIT	0	146,908	73,815	220,723
40.00	04000	SUBPROVIDER - IPF	0	168,202	84,515	252,717
41.00	04100	SUBPROVIDER - IRF	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0
43.00	04300	NURSERY	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	426,939	214,519	641,458
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	522,147	262,358	784,505
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0
55.01	05501	ULTRA SOUND	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	44,794	22,507	67,301
59.00	05900	CARDIAC CATHETERIZATION	0	37,758	18,972	56,730
60.00	06000	LABORATORY	0	243,508	122,353	365,861
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0
66.00	06600	PHYSICAL THERAPY	0	235,683	118,421	354,104
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0
67.01	06701	AUDIOLOGY	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0
69.01	06901	CARDIOLOGY	0	24,288	12,204	36,492
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	100,354	50,424	150,778
90.02	09002	CLINIC	0	161,349	81,071	242,420
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0
90.04	09004	ENT CLINIC	0	0	0	0
90.05	09005	SURGERY CLINIC	0	0	0	0
90.07	09007	UROLOGY CLINIC	0	0	0	0
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0
90.11	09011	NEUROLOGY CLINIC	0	0	0	0
90.12	09012	OPHTHAMOLOGY CLINIC	0	0	0	0
90.13	09013	ALLERGY CLINIC	0	0	0	0
90.14	09014	WOUND CARE	0	92,005	46,229	138,234
91.00	09100	EMERGENCY	0	645,030	324,101	969,131
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	124,983	62,799	187,782
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	5,022,309	2,523,506	7,545,815
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	16,384	8,232	24,616
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,093,554	549,465	1,643,019
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0
194.01	07951	CAFE/BOUQUET	0	47,683	23,959	71,642
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	539,424	271,039	810,463
200.00		Cross Foot Adjustments				0
201.00		Negative Cost Centers		0	0	0
202.00		TOTAL (sum lines 118-201)	0	6,719,354	3,376,201	10,095,555

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 5/29/2014 8:52 am		
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
		5.00	7.00	8.00	9.00	10.00
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	738,744			5.00
7.00	00700	OPERATION OF PLANT	38,242	999,872		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,365	0	2,378	8.00
9.00	00900	HOUSEKEEPING	7,039	15,264	0	133,188
10.00	01000	DIETARY	7,549	34,166	0	8,258
11.00	01100	CAFETERIA	6,272	0	0	2,753
13.00	01300	NURSING ADMINISTRATION	6,349	0	0	1,245
15.00	01500	PHARMACY	18,594	10,547	0	2,514
16.00	01600	MEDICAL RECORDS & LIBRARY	14,501	16,662	0	5,507
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	50,942	110,821	128	41,834
31.00	03100	INTENSIVE CARE UNIT	16,180	30,435	31	11,109
40.00	04000	SUBPROVIDER - IPF	17,276	34,846	20	13,210
41.00	04100	SUBPROVIDER - IRF	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0
43.00	04300	NURSERY	453	0	11	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	37,171	88,448	344	2,466
54.00	05400	RADIOLOGY-DIAGNOSTIC	44,393	108,172	184	11,157
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0
55.01	05501	ULTRA SOUND	4,247	0	62	718
57.00	05700	CT SCAN	7,337	0	247	1,101
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	10,422	9,280	108	1,053
59.00	05900	CARDIAC CATHETERIZATION	5,106	7,822	32	0
60.00	06000	LABORATORY	55,672	50,447	507	4,717
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,812	0	9	0
64.00	06400	INTRAVENOUS THERAPY	0	0	25	0
66.00	06600	PHYSICAL THERAPY	17,829	48,826	47	1,700
67.00	06700	OCCUPATIONAL THERAPY	5,975	0	9	814
67.01	06701	AUDIOLOGY	1,452	0	8	599
68.00	06800	SPEECH PATHOLOGY	836	0	3	359
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0
69.01	06901	CARDIOLOGY	10,988	5,032	88	3,615
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,575	0	38	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	26,043	0	52	0
73.00	07300	DRUGS CHARGED TO PATIENTS	6,210	0	106	2,610
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	4,749	20,790	0	6,416
90.02	09002	CLINIC	2,629	33,426	0	9,433
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0
90.04	09004	ENT CLINIC	1	0	0	0
90.05	09005	SURGERY CLINIC	0	0	0	0
90.07	09007	UROLOGY CLINIC	0	0	1	0
90.09	09009	GASTROENTEROLOGY CLINIC	159	0	0	0
90.11	09011	NEUROLOGY CLINIC	0	0	5	0
90.12	09012	OPHTHALMOLOGY CLINIC	142	0	1	0
90.13	09013	ALLERGY CLINIC	2,095	0	16	0
90.14	09014	WOUND CARE	6,431	19,060	20	0
91.00	09100	EMERGENCY	44,270	133,630	227	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	20,739	9,574	49	0
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	518,045	787,248	2,378	133,188
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	267	3,394	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	209,251	199,352	0	0
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0
194.01	07951	CAFE/BOUTIQUE	777	9,878	0	0
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	10,404	0	0	0
200.00		Cross Foot Adjustments				
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	738,744	999,872	2,378	133,188

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 150104		Period: From 01/01/2013 To 12/31/2013		Worksheet B Part II Date/Time Prepared: 5/29/2014 8:52 am	
Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	15.00	16.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
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	9,210					11.00
13.00	01300	NURSING ADMINISTRATION	178	8,040				13.00
15.00	01500	PHARMACY	356	0	108,738			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	722	0	0	158,706		16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,428	1,881	232	39,001	1,226,401	30.00
31.00	03100	INTENSIVE CARE UNIT	197	572	60	8,109	340,223	31.00
40.00	04000	SUBPROVIDER - IPF	310	883	9	9,654	401,325	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	464	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	216	1,369	2,524	13,998	788,993	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	263	0	88	37,456	986,787	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	28	0	94	4,055	9,343	55.01
57.00	05700	CT SCAN	38	0	151	4,634	13,585	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	94	0	920	2,510	91,841	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	111	47	0	69,944	59.00
60.00	06000	LABORATORY	769	0	27	3,861	482,931	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	1,821	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	25	64.00
66.00	06600	PHYSICAL THERAPY	385	559	50	7,530	431,576	66.00
67.00	06700	OCCUPATIONAL THERAPY	159	188	1,992	3,282	12,607	67.00
67.01	06701	AUDIOLOGY	169	115	0	0	2,421	67.01
68.00	06800	SPEECH PATHOLOGY	178	35	0	0	1,446	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	385	503	49	7,240	64,811	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	197	0	0	0	15,810	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	26,095	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	8,926	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	319	129	20	16,218	199,512	90.01
90.02	09002	CLINIC	0	0	0	0	287,908	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	1	90.04
90.05	09005	SURGERY CLINIC	0	0	7	0	7	90.05
90.07	09007	UROLOGY CLINIC	0	0	107	0	108	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	115	0	0	289	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	5	90.11
90.12	09012	OPHTHALMOLOGY CLINIC	0	0	22	0	165	90.12
90.13	09013	ALLERGY CLINIC	0	72	170	0	2,425	90.13
90.14	09014	WOUND CARE	600	160	463	0	165,087	90.14
91.00	09100	EMERGENCY	0	1,297	6,999	0	1,156,758	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,219	0	1,060	0	221,153	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,210	7,989	15,091	157,548	7,010,793	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	28,277	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	47	93,647	1,158	2,153,299	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	0	0	0	82,297	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	4	0	0	820,889	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	9,210	8,040	108,738	158,706	10,095,555	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 5/29/2014 8:52 am
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
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
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	1,226,401	30.00
31.00	03100	INTENSIVE CARE UNIT	340,223	31.00
40.00	04000	SUBPROVIDER - I/PF	401,325	40.00
41.00	04100	SUBPROVIDER - I/RF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	464	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	788,993	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	986,787	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
55.01	05501	ULTRA SOUND	9,343	55.01
57.00	05700	CT SCAN	13,585	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	91,841	58.00
59.00	05900	CARDIAC CATHETERIZATION	69,944	59.00
60.00	06000	LABORATORY	482,931	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,821	63.00
64.00	06400	INTRAVENOUS THERAPY	25	64.00
66.00	06600	PHYSICAL THERAPY	431,576	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,607	67.00
67.01	06701	AUDIOLOGY	2,421	67.01
68.00	06800	SPEECH PATHOLOGY	1,446	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
69.01	06901	CARDIOLOGY	64,811	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,810	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	26,095	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,926	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	199,512	90.01
90.02	09002	CLINIC	287,908	90.02
90.03	09003	DERMATOLOGY CLINIC	0	90.03
90.04	09004	ENT CLINIC	1	90.04
90.05	09005	SURGERY CLINIC	7	90.05
90.07	09007	UROLOGY CLINIC	108	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	289	90.09
90.11	09011	NEUROLOGY CLINIC	5	90.11
90.12	09012	OPHTHAMOLOGY CLINIC	165	90.12
90.13	09013	ALLERGY CLINIC	2,425	90.13
90.14	09014	WOUND CARE	165,087	90.14
91.00	09100	EMERGENCY	1,156,758	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	221,153	95.00
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,010,793	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	28,277	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,153,299	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	194.00
194.01	07951	CAFE/BOUTIQUE	82,297	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	820,889	194.02
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118-201)	10,095,555	202.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet B-1 Date/Time Prepared: 5/29/2014 8:52 am
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	255,907				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		255,907			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	582	582	39,019,199		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	18,600	18,600	8,456,884	-18,056,886	5.00
7.00 00700	OPERATION OF PLANT	24,368	24,368	527,721	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	21,846	0	8.00
9.00 00900	HOUSEKEEPING	2,806	2,806	320,060	0	9.00
10.00 01000	DIETARY	6,281	6,281	258,427	0	10.00
11.00 01100	CAFETERIA	0	0	314,058	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	456,066	0	13.00
15.00 01500	PHARMACY	1,939	1,939	398,768	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	3,063	3,063	813,952	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	20,373	20,373	2,691,211	0	30.00
31.00 03100	INTENSIVE CARE UNIT	5,595	5,595	925,858	0	31.00
40.00 04000	SUBPROVIDER - IPF	6,406	6,406	998,961	0	40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	16,260	16,260	1,699,071	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	19,886	19,886	968,077	0	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
55.01 05501	ULTRA SOUND	0	0	236,019	0	55.01
57.00 05700	CT SCAN	0	0	131,272	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	1,706	1,706	260,428	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	1,438	1,438	163,901	0	59.00
60.00 06000	LABORATORY	9,274	9,274	1,820,449	0	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00 06600	PHYSICAL THERAPY	8,976	8,976	927,889	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	320,212	0	67.00
67.01 06701	AUDIOLOGY	0	0	131,908	0	67.01
68.00 06800	SPEECH PATHOLOGY	0	0	59,235	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01 06901	CARDIOLOGY	925	925	712,311	0	69.01
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
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 09001	OTHER OUTPATIENT SERVICE COST CENTER	3,822	3,822	158,082	0	90.01
90.02 09002	CLINIC	6,145	6,145	0	0	90.02
90.03 09003	DERMATOLOGY CLINIC	0	0	0	0	90.03
90.04 09004	ENT CLINIC	0	0	0	0	90.04
90.05 09005	SURGERY CLINIC	0	0	0	0	90.05
90.07 09007	UROLOGY CLINIC	0	0	0	0	90.07
90.09 09009	GASTROENTEROLOGY CLINIC	0	0	26,092	0	90.09
90.11 09011	NEUROLOGY CLINIC	0	0	0	0	90.11
90.12 09012	OPHTHALMOLOGY CLINIC	0	0	0	0	90.12
90.13 09013	ALLERGY CLINIC	0	0	123,263	0	90.13
90.14 09014	WOUND CARE	3,504	3,504	203,007	0	90.14
91.00 09100	EMERGENCY	24,566	24,566	2,047,780	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	4,760	4,760	1,241,224	0	95.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	191,275	191,275	27,414,032	-18,056,886	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	624	624	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	41,648	41,648	11,574,614	0	192.00
194.00 07950	THORNTOWN OFFICE BUILDING	0	0	0	0	194.00
194.01 07951	CAFE/BOUTIQUE	1,816	1,816	0	0	194.01
194.02 07952	OTHER NONREIMBURSABLE COST CENTERS	20,544	20,544	30,553	0	194.02
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	6,719,354	3,376,201	7,592,898	18,056,886	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150104

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

Worksheet B-1

Date/Time Prepared:
5/29/2014 8:52 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00				
203.00	Unit cost multiplier (Wkst. B, Part I)	26.257015	13.193078	0.194594		0.265024	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			22,960		738,744	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000588		0.010843	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150104

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

Worksheet B-1
Date/Time Prepared:
5/29/2014 8:52 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (GROSS CHARGES)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	183,813				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	227,672,930			8.00
9.00	00900	HOUSEKEEPING	2,806	0	139,073		9.00
10.00	01000	DIETARY	6,281	0	8,623	32,594	10.00
11.00	01100	CAFETERIA	0	0	2,875	0	982
13.00	01300	NURSING ADMINISTRATION	0	0	1,300	0	19
15.00	01500	PHARMACY	1,939	0	2,625	0	38
16.00	01600	MEDICAL RECORDS & LIBRARY	3,063	0	5,750	0	77
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	20,373	12,824,774	43,681	19,019	259
31.00	03100	INTENSIVE CARE UNIT	5,595	3,130,918	11,600	5,718	21
40.00	04000	SUBPROVIDER - IPF	6,406	1,961,294	13,794	7,857	33
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	1,068,604	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	16,260	34,439,328	2,575	0	23
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,886	18,432,169	11,650	0	28
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
55.01	05501	ULTRA SOUND	0	6,157,491	750	0	3
57.00	05700	CT SCAN	0	24,659,181	1,150	0	4
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,706	10,817,932	1,100	0	10
59.00	05900	CARDIAC CATHETERIZATION	1,438	3,162,166	0	0	0
60.00	06000	LABORATORY	9,274	40,558,132	4,925	0	82
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	891,554	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	2,531,452	0	0	0
66.00	06600	PHYSICAL THERAPY	8,976	4,742,516	1,775	0	41
67.00	06700	OCCUPATIONAL THERAPY	0	939,321	850	0	17
67.01	06701	AUDIOLOGY	0	750,853	625	0	18
68.00	06800	SPEECH PATHOLOGY	0	328,828	375	0	19
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
69.01	06901	CARDIOLOGY	925	8,770,838	3,775	0	41
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,776,168	0	0	21
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	5,235,364	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,578,682	2,725	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	3,822	0	6,700	0	34
90.02	09002	CLINIC	6,145	0	9,850	0	0
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0
90.04	09004	ENT CLINIC	0	0	0	0	0
90.05	09005	SURGERY CLINIC	0	0	0	0	0
90.07	09007	UROLOGY CLINIC	0	127,960	0	0	0
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0
90.11	09011	NEUROLOGY CLINIC	0	491,353	0	0	0
90.12	09012	OPHTHALMOLOGY CLINIC	0	121,521	0	0	0
90.13	09013	ALLERGY CLINIC	0	1,644,707	0	0	0
90.14	09014	WOUND CARE	3,504	1,976,706	0	0	64
91.00	09100	EMERGENCY	24,566	22,701,138	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,760	4,851,980	0	0	130
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	144,725	227,672,930	139,073	32,594	982
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	624	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	36,648	0	0	0	0
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0
194.01	07951	CAFE/BOUTIQUE	1,816	0	0	0	0
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	4,461,600	275,892	889,351	1,088,275	750,103
203.00		Unit cost multiplier (Wkst. B, Part I)	24.272494	0.001212	6.394850	33.388814	763.852342
204.00		Cost to be allocated (per Wkst. B, Part II)	999,872	2,378	133,188	297,911	9,210

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150104

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

Worksheet B-1

Date/Time Prepared:
5/29/2014 8:52 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (GROSS CHARGES)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	5.439615	0.000010	0.957684	9.140056	9.378819	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150104

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

Worksheet B-1
Date/Time Prepared:
5/29/2014 8:52 am

Cost Center Description		NURSING ADMINISTRATIVE (DIRECT NRSING HRS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		13.00	15.00	16.00	
GENERAL SERVICE COST CENTERS					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP				2.00
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	349,149			13.00
15.00	01500 PHARMACY	0	1,019,639		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	41,100	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	81,653	2,178	10,100	30.00
31.00	03100 INTENSIVE CARE UNIT	24,832	558	2,100	31.00
40.00	04000 SUBPROVIDER - IPF	38,327	83	2,500	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	42.00
43.00	04300 NURSERY	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	59,449	23,667	3,625	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	825	9,700	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
55.01	05501 ULTRA SOUND	0	878	1,050	55.01
57.00	05700 CT SCAN	0	1,412	1,200	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	8,628	650	58.00
59.00	05900 CARDIAC CATHETERIZATION	4,842	441	0	59.00
60.00	06000 LABORATORY	0	254	1,000	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
66.00	06600 PHYSICAL THERAPY	24,297	471	1,950	66.00
67.00	06700 OCCUPATIONAL THERAPY	8,166	18,677	850	67.00
67.01	06701 AUDIOLOGY	4,985	0	0	67.01
68.00	06800 SPEECH PATHOLOGY	1,516	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
69.01	06901 CARDIOLOGY	21,824	464	1,875	69.01
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
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0	90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	5,618	190	4,200	90.01
90.02	09002 CLINIC	0	0	0	90.02
90.03	09003 DERMATOLOGY CLINIC	0	0	0	90.03
90.04	09004 ENT CLINIC	0	0	0	90.04
90.05	09005 SURGERY CLINIC	0	69	0	90.05
90.07	09007 UROLOGY CLINIC	0	1,008	0	90.07
90.09	09009 GASTROENTEROLOGY CLINIC	5,006	0	0	90.09
90.11	09011 NEUROLOGY CLINIC	0	3	0	90.11
90.12	09012 OPHTHAMOLOGY CLINIC	0	204	0	90.12
90.13	09013 ALLERGY CLINIC	3,136	1,595	0	90.13
90.14	09014 WOUND CARE	6,966	4,340	0	90.14
91.00	09100 EMERGENCY	56,326	65,626	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0	9,940	0	95.00
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1-117)	346,943	141,511	40,800	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	2,024	878,128	300	192.00
194.00	07950 THORNTOWN OFFICE BUILDING	0	0	0	194.00
194.01	07951 CAFE/BOUTIQUE	0	0	0	194.01
194.02	07952 OTHER NONREIMBURSABLE COST CENTERS	182	0	0	194.02
200.00	Cross Foot Adjustments				200.00
201.00	Negative Cost Centers				201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	763,592	2,262,201	1,861,758	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	2.187009	2.218629	45.298248	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150104

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

Worksheet B-1
Date/Time Prepared:
5/29/2014 8:52 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURSING HRS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		13.00	15.00	16.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	8,040	108,738	158,706	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.023027	0.106644	3.861460	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150104

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2014 8:52 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		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,206,432		8,206,432	0	8,206,432	30.00
31.00	03100	INTENSIVE CARE UNIT	2,459,064		2,459,064	0	2,459,064	31.00
40.00	04000	SUBPROVIDER - IPF	2,746,458		2,746,458	33,150	2,779,608	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	54,173		54,173	0	54,173	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,153,840		5,153,840	0	5,153,840	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,221,341		6,221,341	0	6,221,341	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
55.01	05501	ULTRA SOUND	559,604		559,604	0	559,604	55.01
57.00	05700	CT SCAN	953,736		953,736	0	953,736	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,333,685		1,333,685	0	1,333,685	58.00
59.00	05900	CARDIAC CATHETERIZATION	645,999		645,999	0	645,999	59.00
60.00	06000	LABORATORY	6,909,347		6,909,347	0	6,909,347	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	212,493		212,493	0	212,493	63.00
64.00	06400	INTRAVENOUS THERAPY	3,068		3,068	0	3,068	64.00
66.00	06600	PHYSICAL THERAPY	2,488,908	0	2,488,908	0	2,488,908	66.00
67.00	06700	OCCUPATIONAL THERAPY	814,457	0	814,457	0	814,457	67.00
67.01	06701	AUDIOLOGY	199,005	0	199,005	0	199,005	67.01
68.00	06800	SPEECH PATHOLOGY	118,110	0	118,110	0	118,110	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	06901	CARDIOLOGY	1,504,126		1,504,126	0	1,504,126	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,837,744		1,837,744	0	1,837,744	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,044,702		3,044,702	0	3,044,702	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	754,801		754,801	0	754,801	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	918,578		918,578	0	918,578	90.01
90.02	09002	CLINIC	518,810		518,810	0	518,810	90.02
90.03	09003	DERMATOLOGY CLINIC	0		0	0	0	90.03
90.04	09004	ENT CLINIC	125		125	0	125	90.04
90.05	09005	SURGERY CLINIC	153		153	0	153	90.05
90.07	09007	UROLOGY CLINIC	2,391		2,391	0	2,391	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	29,502		29,502	0	29,502	90.09
90.11	09011	NEUROLOGY CLINIC	603		603	0	603	90.11
90.12	09012	OPHTHALMOLOGY CLINIC	17,120		17,120	0	17,120	90.12
90.13	09013	ALLERGY CLINIC	256,831		256,831	0	256,831	90.13
90.14	09014	WOUND CARE	911,519		911,519	0	911,519	90.14
91.00	09100	EMERGENCY	6,057,420		6,057,420	0	6,057,420	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,816,685		1,816,685	0	1,816,685	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	2,589,536		2,589,536	0	2,589,536	95.00
200.00		Subtotal (see instructions)	59,340,366	0	59,340,366	33,150	59,373,516	200.00
201.00		Less Observation Beds	1,816,685		1,816,685		1,816,685	201.00
202.00		Total (see instructions)	57,523,681	0	57,523,681	33,150	57,556,831	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 150104		Period: From 01/01/2013 To 12/31/2013		Worksheet C Part I Date/Time Prepared: 5/29/2014 8:52 am	
			Title XVII I		Hospital		PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00	9.00	10.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,373,451		10,373,451		30.00	
31.00	03100	INTENSIVE CARE UNIT	3,130,918		3,130,918		31.00	
40.00	04000	SUBPROVIDER - IPF	1,961,294		1,961,294		40.00	
41.00	04100	SUBPROVIDER - IRF	0		0		41.00	
42.00	04200	SUBPROVIDER	0		0		42.00	
43.00	04300	NURSERY	1,068,604		1,068,604		43.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,968,295	28,471,033	34,439,328	0.149650	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,118,215	17,313,954	18,432,169	0.337526	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	55.00	
55.01	05501	ULTRA SOUND	500,105	5,657,386	6,157,491	0.090882	55.01	
57.00	05700	CT SCAN	2,833,104	21,826,077	24,659,181	0.038677	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	509,513	10,308,419	10,817,932	0.123285	58.00	
59.00	05900	CARDIAC CATHETERIZATION	1,352,049	1,810,117	3,162,166	0.204290	59.00	
60.00	06000	LABORATORY	7,865,989	32,692,143	40,558,132	0.170357	60.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	424,797	466,757	891,554	0.238340	63.00	
64.00	06400	INTRAVENOUS THERAPY	1,099,248	1,432,204	2,531,452	0.001212	64.00	
66.00	06600	PHYSICAL THERAPY	598,634	4,143,882	4,742,516	0.524808	66.00	
67.00	06700	OCCUPATIONAL THERAPY	286,783	652,538	939,321	0.867070	67.00	
67.01	06701	AUDIOLOGY	0	750,853	750,853	0.265039	67.01	
68.00	06800	SPEECH PATHOLOGY	35,734	293,094	328,828	0.359185	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00	
69.01	06901	CARDIOLOGY	3,580,190	5,190,648	8,770,838	0.171492	69.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,694,917	2,081,251	3,776,168	0.486669	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,426,136	2,809,228	5,235,364	0.581565	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	5,401,660	5,177,022	10,578,682	0.071351	73.00	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0.000000	90.00	
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	90.01	
90.02	09002	CLINIC	0	0	0	0.000000	90.02	
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0.000000	90.03	
90.04	09004	ENT CLINIC	0	0	0	0.000000	90.04	
90.05	09005	SURGERY CLINIC	0	0	0	0.000000	90.05	
90.07	09007	UROLOGY CLINIC	981	126,979	127,960	0.018686	90.07	
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0.000000	90.09	
90.11	09011	NEUROLOGY CLINIC	0	491,353	491,353	0.001227	90.11	
90.12	09012	OPHTHAMOLOGY CLINIC	160	121,361	121,521	0.140881	90.12	
90.13	09013	ALLERGY CLINIC	0	1,644,707	1,644,707	0.156156	90.13	
90.14	09014	WOUND CARE	5,574	1,971,132	1,976,706	0.461130	90.14	
91.00	09100	EMERGENCY	2,574,393	20,126,745	22,701,138	0.266833	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,451,323	2,451,323	0.741104	92.00	
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	14,516	4,837,464	4,851,980	0.533707	95.00	
200.00		Subtotal (see instructions)	54,825,260	172,847,670	227,672,930		200.00	
201.00		Less Observation Beds					201.00	
202.00		Total (see instructions)	54,825,260	172,847,670	227,672,930		202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/29/2014 8:52 am
Cost Center Description		PPS Inpatient Ratio	Title XVII I	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.149650		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.337526		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000		55.00
55.01	05501 ULTRA SOUND	0.090882		55.01
57.00	05700 CT SCAN	0.038677		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.123285		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.204290		59.00
60.00	06000 LABORATORY	0.170357		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.238340		63.00
64.00	06400 INTRAVENOUS THERAPY	0.001212		64.00
66.00	06600 PHYSICAL THERAPY	0.524808		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.867070		67.00
67.01	06701 AUDIOLOGY	0.265039		67.01
68.00	06800 SPEECH PATHOLOGY	0.359185		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901 CARDIOLOGY	0.171492		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.486669		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.581565		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.071351		73.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0.000000		90.01
90.02	09002 CLINIC	0.000000		90.02
90.03	09003 DERMATOLOGY CLINIC	0.000000		90.03
90.04	09004 ENT CLINIC	0.000000		90.04
90.05	09005 SURGERY CLINIC	0.000000		90.05
90.07	09007 UROLOGY CLINIC	0.018686		90.07
90.09	09009 GASTROENTEROLOGY CLINIC	0.000000		90.09
90.11	09011 NEUROLOGY CLINIC	0.001227		90.11
90.12	09012 OPHTHALMOLOGY CLINIC	0.140881		90.12
90.13	09013 ALLERGY CLINIC	0.156156		90.13
90.14	09014 WOUND CARE	0.461130		90.14
91.00	09100 EMERGENCY	0.266833		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.741104		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0.533707		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: 150104

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

Worksheet C
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		Title XIX		Hospital		Cost		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs		
				Total Costs	RCE Disallowance			
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,206,432		8,206,432	0	8,206,432	30.00
31.00	03100	INTENSIVE CARE UNIT	2,459,064		2,459,064	0	2,459,064	31.00
40.00	04000	SUBPROVIDER - IPF	2,746,458		2,746,458	33,150	2,779,608	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	54,173		54,173	0	54,173	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,153,840		5,153,840	0	5,153,840	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,221,341		6,221,341	0	6,221,341	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
55.01	05501	ULTRA SOUND	559,604		559,604	0	559,604	55.01
57.00	05700	CT SCAN	953,736		953,736	0	953,736	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,333,685		1,333,685	0	1,333,685	58.00
59.00	05900	CARDIAC CATHETERIZATION	645,999		645,999	0	645,999	59.00
60.00	06000	LABORATORY	6,909,347		6,909,347	0	6,909,347	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	212,493		212,493	0	212,493	63.00
64.00	06400	INTRAVENOUS THERAPY	3,068		3,068	0	3,068	64.00
66.00	06600	PHYSICAL THERAPY	2,488,908	0	2,488,908	0	2,488,908	66.00
67.00	06700	OCCUPATIONAL THERAPY	814,457	0	814,457	0	814,457	67.00
67.01	06701	AUDIOLOGY	199,005	0	199,005	0	199,005	67.01
68.00	06800	SPEECH PATHOLOGY	118,110	0	118,110	0	118,110	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	06901	CARDIOLOGY	1,504,126		1,504,126	0	1,504,126	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,837,744		1,837,744	0	1,837,744	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,044,702		3,044,702	0	3,044,702	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	754,801		754,801	0	754,801	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	918,578		918,578	0	918,578	90.01
90.02	09002	CLINIC	518,810		518,810	0	518,810	90.02
90.03	09003	DERMATOLOGY CLINIC	0		0	0	0	90.03
90.04	09004	ENT CLINIC	125		125	0	125	90.04
90.05	09005	SURGERY CLINIC	153		153	0	153	90.05
90.07	09007	UROLOGY CLINIC	2,391		2,391	0	2,391	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	29,502		29,502	0	29,502	90.09
90.11	09011	NEUROLOGY CLINIC	603		603	0	603	90.11
90.12	09012	OPHTHALMOLOGY CLINIC	17,120		17,120	0	17,120	90.12
90.13	09013	ALLERGY CLINIC	256,831		256,831	0	256,831	90.13
90.14	09014	WOUND CARE	911,519		911,519	0	911,519	90.14
91.00	09100	EMERGENCY	6,057,420		6,057,420	0	6,057,420	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,816,685		1,816,685	0	1,816,685	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	2,589,536		2,589,536	0	2,589,536	95.00
200.00		Subtotal (see instructions)	59,340,366	0	59,340,366	33,150	59,373,516	200.00
201.00		Less Observation Beds	1,816,685		1,816,685		1,816,685	201.00
202.00		Total (see instructions)	57,523,681	0	57,523,681	33,150	57,556,831	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150104

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

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		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	10,373,451		10,373,451		30.00
31.00	03100	INTENSIVE CARE UNIT	3,130,918		3,130,918		31.00
40.00	04000	SUBPROVIDER - IPF	1,961,294		1,961,294		40.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	1,068,604		1,068,604		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,968,295	28,471,033	34,439,328	0.149650	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,118,215	17,313,954	18,432,169	0.337526	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	55.00
55.01	05501	ULTRA SOUND	500,105	5,657,386	6,157,491	0.090882	55.01
57.00	05700	CT SCAN	2,833,104	21,826,077	24,659,181	0.038677	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	509,513	10,308,419	10,817,932	0.123285	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,352,049	1,810,117	3,162,166	0.204290	59.00
60.00	06000	LABORATORY	7,865,989	32,692,143	40,558,132	0.170357	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	424,797	466,757	891,554	0.238340	63.00
64.00	06400	INTRAVENOUS THERAPY	1,099,248	1,432,204	2,531,452	0.001212	64.00
66.00	06600	PHYSICAL THERAPY	598,634	4,143,882	4,742,516	0.524808	66.00
67.00	06700	OCCUPATIONAL THERAPY	286,783	652,538	939,321	0.867070	67.00
67.01	06701	AUDIOLOGY	0	750,853	750,853	0.265039	67.01
68.00	06800	SPEECH PATHOLOGY	35,734	293,094	328,828	0.359185	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
69.01	06901	CARDIOLOGY	3,580,190	5,190,648	8,770,838	0.171492	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,694,917	2,081,251	3,776,168	0.486669	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,426,136	2,809,228	5,235,364	0.581565	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,401,660	5,177,022	10,578,682	0.071351	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	90.01
90.02	09002	CLINIC	0	0	0	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0.000000	90.03
90.04	09004	ENT CLINIC	0	0	0	0.000000	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0.000000	90.05
90.07	09007	UROLOGY CLINIC	981	126,979	127,960	0.018686	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	0	491,353	491,353	0.001227	90.11
90.12	09012	OPHTHAMOLOGY CLINIC	160	121,361	121,521	0.140881	90.12
90.13	09013	ALLERGY CLINIC	0	1,644,707	1,644,707	0.156156	90.13
90.14	09014	WOUND CARE	5,574	1,971,132	1,976,706	0.461130	90.14
91.00	09100	EMERGENCY	2,574,393	20,126,745	22,701,138	0.266833	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,451,323	2,451,323	0.741104	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	14,516	4,837,464	4,851,980	0.533707	95.00
200.00		Subtotal (see instructions)	54,825,260	172,847,670	227,672,930		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	54,825,260	172,847,670	227,672,930		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150104

Period:
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Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF				40.00
41.00	04100 SUBPROVIDER - IRF				41.00
42.00	04200 SUBPROVIDER				42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000			55.00
55.01	05501 ULTRA SOUND	0.000000			55.01
57.00	05700 CT SCAN	0.000000			57.00
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
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
67.01	06701 AUDIOLOGY	0.000000			67.01
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
69.01	06901 CARDIOLOGY	0.000000			69.01
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
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0.000000			90.01
90.02	09002 CLINIC	0.000000			90.02
90.03	09003 DERMATOLOGY CLINIC	0.000000			90.03
90.04	09004 ENT CLINIC	0.000000			90.04
90.05	09005 SURGERY CLINIC	0.000000			90.05
90.07	09007 UROLOGY CLINIC	0.000000			90.07
90.09	09009 GASTROENTEROLOGY CLINIC	0.000000			90.09
90.11	09011 NEUROLOGY CLINIC	0.000000			90.11
90.12	09012 OPHTHALMOLOGY CLINIC	0.000000			90.12
90.13	09013 ALLERGY CLINIC	0.000000			90.13
90.14	09014 WOUND CARE	0.000000			90.14
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part I Date/Time Prepared: 5/29/2014 8:52 am
		Title XVIII	Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,226,401	0	1,226,401	6,288	195.04	30.00
31.00	INTENSIVE CARE UNIT	340,223		340,223	1,502	226.51	31.00
40.00	SUBPROVIDER - IPF	401,325	0	401,325	2,075	193.41	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	464		464	921	0.50	43.00
200.00	Total (lines 30-199)	1,968,413		1,968,413	10,786		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	2,210	431,038				
31.00	INTENSIVE CARE UNIT	590	133,641				
40.00	SUBPROVIDER - IPF	1,874	362,450				
41.00	SUBPROVIDER - IRF	0	0				
42.00	SUBPROVIDER	0	0				
43.00	NURSERY	0	0				
200.00	Total (lines 30-199)	4,674	927,129				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/29/2014 8:52 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	788,993	34,439,328	0.022910	2,303,354	52,770	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	986,787	18,432,169	0.053536	593,207	31,758	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
55.01	05501 ULTRA SOUND	9,343	6,157,491	0.001517	238,917	362	55.01
57.00	05700 CT SCAN	13,585	24,659,181	0.000551	1,344,466	741	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	91,841	10,817,932	0.008490	216,852	1,841	58.00
59.00	05900 CARDIAC CATHETERIZATION	69,944	3,162,166	0.022119	716,674	15,852	59.00
60.00	06000 LABORATORY	482,931	40,558,132	0.011907	3,838,608	45,706	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1,821	891,554	0.002043	126,245	258	63.00
64.00	06400 INTRAVENOUS THERAPY	25	2,531,452	0.000010	453,143	5	64.00
66.00	06600 PHYSICAL THERAPY	431,576	4,742,516	0.091001	303,535	27,622	66.00
67.00	06700 OCCUPATIONAL THERAPY	12,607	939,321	0.013421	171,163	2,297	67.00
67.01	06701 AUDIOLOGY	2,421	750,853	0.003224	0	0	67.01
68.00	06800 SPEECH PATHOLOGY	1,446	328,828	0.004397	21,938	96	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	06901 CARDIOLOGY	64,811	8,770,838	0.007389	1,999,467	14,774	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	15,810	3,776,168	0.004187	578,162	2,421	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	26,095	5,235,364	0.004984	1,054,320	5,255	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8,926	10,578,682	0.000844	2,502,235	2,112	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	199,512	0	0.000000	0	0	90.01
90.02	09002 CLINIC	287,908	0	0.000000	0	0	90.02
90.03	09003 DERMATOLOGY CLINIC	0	0	0.000000	0	0	90.03
90.04	09004 ENT CLINIC	1	0	0.000000	0	0	90.04
90.05	09005 SURGERY CLINIC	7	0	0.000000	0	0	90.05
90.07	09007 UROLOGY CLINIC	108	127,960	0.000844	890	1	90.07
90.09	09009 GASTROENTEROLOGY CLINIC	289	0	0.000000	0	0	90.09
90.11	09011 NEUROLOGY CLINIC	5	491,353	0.000010	0	0	90.11
90.12	09012 OPHTHALMOLOGY CLINIC	165	121,521	0.001358	160	0	90.12
90.13	09013 ALLERGY CLINIC	2,425	1,644,707	0.001474	0	0	90.13
90.14	09014 WOUND CARE	165,087	1,976,706	0.083516	2,325	194	90.14
91.00	09100 EMERGENCY	1,156,758	22,701,138	0.050956	1,345,885	68,581	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	271,493	2,451,323	0.110754	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	5,092,720	206,286,683		17,811,546	272,646	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part III Date/Time Prepared: 5/29/2014 8:52 am
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Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00	
42.00	04200	SUBPROVIDER	0	0	0	0	42.00	
43.00	04300	NURSERY	0	0	0	0	43.00	
200.00		Total (lines 30-199)	0	0	0	0	200.00	
Cost Center Description			Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,288	0.00	2,210	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	1,502	0.00	590	0	31.00	
40.00	04000	SUBPROVIDER - IPF	2,075	0.00	1,874	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0	41.00	
42.00	04200	SUBPROVIDER	0	0.00	0	0	42.00	
43.00	04300	NURSERY	921	0.00	0	0	43.00	
200.00		Total (lines 30-199)	10,786		4,674	0	200.00	
Cost Center Description			PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost				
			12.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0				30.00
31.00	03100	INTENSIVE CARE UNIT	0	0				31.00
40.00	04000	SUBPROVIDER - IPF	0	0				40.00
41.00	04100	SUBPROVIDER - IRF	0	0				41.00
42.00	04200	SUBPROVIDER	0	0				42.00
43.00	04300	NURSERY	0	0				43.00
200.00		Total (lines 30-199)	0	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150104

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

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Title XVIII				Hospital	PPS	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	0	0	0	55.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
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
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
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0	0	0	0	0	69.01
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
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPHTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	0	0	90.13
90.14	09014	WOUND CARE	0	0	0	0	0	90.14
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	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: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/29/2014 8:52 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)	Hospital		Inpatient Program Charges	
				PPS			
				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)			
Title XVIII							
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	34,439,328	0.000000	0.000000		2,303,354	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	18,432,169	0.000000	0.000000		593,207	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000		0	55.00
55.01 05501 ULTRA SOUND	0	6,157,491	0.000000	0.000000		238,917	55.01
57.00 05700 CT SCAN	0	24,659,181	0.000000	0.000000		1,344,466	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	10,817,932	0.000000	0.000000		216,852	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	3,162,166	0.000000	0.000000		716,674	59.00
60.00 06000 LABORATORY	0	40,558,132	0.000000	0.000000		3,838,608	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	891,554	0.000000	0.000000		126,245	63.00
64.00 06400 INTRAVENOUS THERAPY	0	2,531,452	0.000000	0.000000		453,143	64.00
66.00 06600 PHYSICAL THERAPY	0	4,742,516	0.000000	0.000000		303,535	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	939,321	0.000000	0.000000		171,163	67.00
67.01 06701 AUDIOLOGY	0	750,853	0.000000	0.000000		0	67.01
68.00 06800 SPEECH PATHOLOGY	0	328,828	0.000000	0.000000		21,938	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000		0	69.00
69.01 06901 CARDIOLOGY	0	8,770,838	0.000000	0.000000		1,999,467	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,776,168	0.000000	0.000000		578,162	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	5,235,364	0.000000	0.000000		1,054,320	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	10,578,682	0.000000	0.000000		2,502,235	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0	0	0.000000	0.000000		0	90.00
90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000		0	90.01
90.02 09002 CLINIC	0	0	0.000000	0.000000		0	90.02
90.03 09003 DERMATOLOGY CLINIC	0	0	0.000000	0.000000		0	90.03
90.04 09004 ENT CLINIC	0	0	0.000000	0.000000		0	90.04
90.05 09005 SURGERY CLINIC	0	0	0.000000	0.000000		0	90.05
90.07 09007 UROLOGY CLINIC	0	127,960	0.000000	0.000000		890	90.07
90.09 09009 GASTROENTEROLOGY CLINIC	0	0	0.000000	0.000000		0	90.09
90.11 09011 NEUROLOGY CLINIC	0	491,353	0.000000	0.000000		0	90.11
90.12 09012 OPHTHAMOLOGY CLINIC	0	121,521	0.000000	0.000000		160	90.12
90.13 09013 ALLERGY CLINIC	0	1,644,707	0.000000	0.000000		0	90.13
90.14 09014 WOUND CARE	0	1,976,706	0.000000	0.000000		2,325	90.14
91.00 09100 EMERGENCY	0	22,701,138	0.000000	0.000000		1,345,885	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2,451,323	0.000000	0.000000		0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500 AMBULANCE SERVICES	0	0					95.00
200.00 Total (lines 50-199)	0	206,286,683				17,811,546	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150104

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

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description			Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	PPS
ANCILLARY SERVICE COST CENTERS			11.00	12.00	13.00	21.00	22.00	
50.00	05000	OPERATING ROOM	0	8,067,499	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,889,463	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	1,373,846	0	0	0	55.01
57.00	05700	CT SCAN	0	6,054,406	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,232,872	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	838,038	0	0	0	59.00
60.00	06000	LABORATORY	0	381,659	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	164,457	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	290,541	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	9,449	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0	124,664	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0	1,637,056	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	438,876	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	60,728	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,493,579	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	73,860	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	113,794	0	0	0	90.11
90.12	09012	OPHTHAMOLOGY CLINIC	0	61,656	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	130,724	0	0	0	90.13
90.14	09014	WOUND CARE	0	836,824	0	0	0	90.14
91.00	09100	EMERGENCY	0	3,491,136	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,023,682	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50-199)	0	35,788,809	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150104

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

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XVIII	Hospital	PPS
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0			54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0			55.00
55.01	05501 ULTRA SOUND	0	0			55.01
57.00	05700 CT SCAN	0	0			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0			59.00
60.00	06000 LABORATORY	0	0			60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0			63.00
64.00	06400 INTRAVENOUS THERAPY	0	0			64.00
66.00	06600 PHYSICAL THERAPY	0	0			66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0			67.00
67.01	06701 AUDIOLOGY	0	0			67.01
68.00	06800 SPEECH PATHOLOGY	0	0			68.00
69.00	06900 ELECTROCARDIOLOGY	0	0			69.00
69.01	06901 CARDIOLOGY	0	0			69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0			90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0			90.01
90.02	09002 CLINIC	0	0			90.02
90.03	09003 DERMATOLOGY CLINIC	0	0			90.03
90.04	09004 ENT CLINIC	0	0			90.04
90.05	09005 SURGERY CLINIC	0	0			90.05
90.07	09007 UROLOGY CLINIC	0	0			90.07
90.09	09009 GASTROENTEROLOGY CLINIC	0	0			90.09
90.11	09011 NEUROLOGY CLINIC	0	0			90.11
90.12	09012 OPHTHAMOLOGY CLINIC	0	0			90.12
90.13	09013 ALLERGY CLINIC	0	0			90.13
90.14	09014 WOUND CARE	0	0			90.14
91.00	09100 EMERGENCY	0	0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (Lines 50-199)	0	0			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/29/2014 8:52 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.149650	8,067,499	0	21	1,207,301 50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.337526	5,889,463	297	0	1,987,847 54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0 55.00
55.01	05501 ULTRA SOUND	0.090882	1,373,846	0	0	124,858 55.01
57.00	05700 CT SCAN	0.038677	6,054,406	0	4,630	234,166 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.123285	3,232,872	0	0	398,565 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.204290	838,038	0	338	171,203 59.00
60.00	06000 LABORATORY	0.170357	381,659	17,046	0	65,018 60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.238340	164,457	0	0	39,197 63.00
64.00	06400 INTRAVENOUS THERAPY	0.001212	290,541	0	0	352 64.00
66.00	06600 PHYSICAL THERAPY	0.524808	9,449	0	0	4,959 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.867070	0	0	0	0 67.00
67.01	06701 AUDIOLOGY	0.265039	124,664	0	0	33,041 67.01
68.00	06800 SPEECH PATHOLOGY	0.359185	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0 69.00
69.01	06901 RADIOLOGY	0.171492	1,637,056	0	0	280,742 69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.486669	438,876	0	0	213,587 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.581565	60,728	0	0	35,317 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.071351	1,493,579	0	4,948	106,568 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.000000	0	0	0	0 90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0 90.01
90.02	09002 CLINIC	0.000000	0	0	0	0 90.02
90.03	09003 DERMATOLOGY CLINIC	0.000000	0	0	0	0 90.03
90.04	09004 ENT CLINIC	0.000000	0	0	0	0 90.04
90.05	09005 SURGERY CLINIC	0.000000	0	0	0	0 90.05
90.07	09007 UROLOGY CLINIC	0.018686	73,860	0	0	1,380 90.07
90.09	09009 GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0 90.09
90.11	09011 NEUROLOGY CLINIC	0.001227	113,794	0	0	140 90.11
90.12	09012 OPHTHAMOLOGY CLINIC	0.140881	61,656	0	0	8,686 90.12
90.13	09013 ALLERGY CLINIC	0.156156	130,724	0	0	20,413 90.13
90.14	09014 WOUND CARE	0.461130	836,824	0	735	385,885 90.14
91.00	09100 EMERGENCY	0.266833	3,491,136	0	0	931,550 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.741104	1,023,682	0	0	758,655 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0.533707	0	0	0	0 95.00
200.00	Subtotal (see instructions)		35,788,809	17,343	10,672	7,009,430 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00	Net Charges (line 200 +/- line 201)		35,788,809	17,343	10,672	7,009,430 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/29/2014 8:52 am
		Title XVII I	Hospital	PPS

Cost Center Description	Costs		50.00
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	3	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	100	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
55.01 05501 ULTRA SOUND	0	0	55.01
57.00 05700 CT SCAN	0	179	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	69	59.00
60.00 06000 LABORATORY	2,904	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	64.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
67.01 06701 AUDIOLOGY	0	0	67.01
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
69.01 06901 CARDIOLOGY	0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	353	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0	90.01
90.02 09002 CLINIC	0	0	90.02
90.03 09003 DERMATOLOGY CLINIC	0	0	90.03
90.04 09004 ENT CLINIC	0	0	90.04
90.05 09005 SURGERY CLINIC	0	0	90.05
90.07 09007 UROLOGY CLINIC	0	0	90.07
90.09 09009 GASTROENTEROLOGY CLINIC	0	0	90.09
90.11 09011 NEUROLOGY CLINIC	0	0	90.11
90.12 09012 OPHTHAMOLOGY CLINIC	0	0	90.12
90.13 09013 ALLERGY CLINIC	0	0	90.13
90.14 09014 WOUND CARE	0	339	90.14
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS			
95.00 09500 AMBULANCE SERVICES	0	0	95.00
200.00 Subtotal (see instructions)	3,004	943	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00 Net Charges (line 200 +/- line 201)	3,004	943	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150104 Component CCN: 15S104		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part II Date/Time Prepared: 5/29/2014 8:52 am		
		Title XVIII		Subprovider - IPF		PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	788,993	34,439,328	0.022910	10,587	243	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	986,787	18,432,169	0.053536	21,598	1,156	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	9,343	6,157,491	0.001517	11,348	17	55.01
57.00	05700	CT SCAN	13,585	24,659,181	0.000551	29,950	17	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	91,841	10,817,932	0.008490	3,851	33	58.00
59.00	05900	CARDIAC CATHETERIZATION	69,944	3,162,166	0.022119	3,148	70	59.00
60.00	06000	LABORATORY	482,931	40,558,132	0.011907	399,806	4,760	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,821	891,554	0.002043	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	25	2,531,452	0.000010	3,501	0	64.00
66.00	06600	PHYSICAL THERAPY	431,576	4,742,516	0.091001	38,933	3,543	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,607	939,321	0.013421	4,742	64	67.00
67.01	06701	AUDIOLOGY	2,421	750,853	0.003224	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	1,446	328,828	0.004397	1,126	5	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	64,811	8,770,838	0.007389	64,203	474	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,810	3,776,168	0.004187	23,369	98	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	26,095	5,235,364	0.004984	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,926	10,578,682	0.000844	414,391	350	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	199,512	0	0.000000	0	0	90.01
90.02	09002	CLINIC	287,908	0	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	1	0	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	7	0	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	108	127,960	0.000844	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	289	0	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	5	491,353	0.000010	0	0	90.11
90.12	09012	OPHTHAMOLOGY CLINIC	165	121,521	0.001358	0	0	90.12
90.13	09013	ALLERGY CLINIC	2,425	1,644,707	0.001474	0	0	90.13
90.14	09014	WOUND CARE	165,087	1,976,706	0.083516	6	1	90.14
91.00	09100	EMERGENCY	1,156,758	22,701,138	0.050956	15,386	784	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,451,323	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	4,821,227	206,286,683		1,045,945	11,615	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150104 Component CCN: 15S104	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/29/2014 8:52 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501 ULTRA SOUND	0	0	0	0	0	55.01
57.00	05700 CT SCAN	0	0	0	0	0	57.00
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
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
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01	06701 AUDIOLOGY	0	0	0	0	0	67.01
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901 CARDIOLOGY	0	0	0	0	0	69.01
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
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002 CLINIC	0	0	0	0	0	90.02
90.03	09003 DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004 ENT CLINIC	0	0	0	0	0	90.04
90.05	09005 SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007 UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009 GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011 NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012 OPHTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013 ALLERGY CLINIC	0	0	0	0	0	90.13
90.14	09014 WOUND CARE	0	0	0	0	0	90.14
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	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: 150104 Component CCN: 15S104	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/29/2014 8:52 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient	
	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)	Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	34,439,328	0.000000	0.000000	10,587	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	18,432,169	0.000000	0.000000	21,598	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
55.01 05501 ULTRA SOUND	0	6,157,491	0.000000	0.000000	11,348	55.01
57.00 05700 CT SCAN	0	24,659,181	0.000000	0.000000	29,950	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	10,817,932	0.000000	0.000000	3,851	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	3,162,166	0.000000	0.000000	3,148	59.00
60.00 06000 LABORATORY	0	40,558,132	0.000000	0.000000	399,806	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	891,554	0.000000	0.000000	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	2,531,452	0.000000	0.000000	3,501	64.00
66.00 06600 PHYSICAL THERAPY	0	4,742,516	0.000000	0.000000	38,933	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	939,321	0.000000	0.000000	4,742	67.00
67.01 06701 AUDIOLOGY	0	750,853	0.000000	0.000000	0	67.01
68.00 06800 SPEECH PATHOLOGY	0	328,828	0.000000	0.000000	1,126	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
69.01 06901 CARDIOLOGY	0	8,770,838	0.000000	0.000000	64,203	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,776,168	0.000000	0.000000	23,369	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	5,235,364	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	10,578,682	0.000000	0.000000	414,391	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0.000000	0.000000	0	90.00
90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	90.01
90.02 09002 CLINIC	0	0	0.000000	0.000000	0	90.02
90.03 09003 DERMATOLOGY CLINIC	0	0	0.000000	0.000000	0	90.03
90.04 09004 ENT CLINIC	0	0	0.000000	0.000000	0	90.04
90.05 09005 SURGERY CLINIC	0	0	0.000000	0.000000	0	90.05
90.07 09007 UROLOGY CLINIC	0	127,960	0.000000	0.000000	0	90.07
90.09 09009 GASTROENTEROLOGY CLINIC	0	0	0.000000	0.000000	0	90.09
90.11 09011 NEUROLOGY CLINIC	0	491,353	0.000000	0.000000	0	90.11
90.12 09012 OPHTHAMOLOGY CLINIC	0	121,521	0.000000	0.000000	0	90.12
90.13 09013 ALLERGY CLINIC	0	1,644,707	0.000000	0.000000	0	90.13
90.14 09014 WOUND CARE	0	1,976,706	0.000000	0.000000	6	90.14
91.00 09100 EMERGENCY	0	22,701,138	0.000000	0.000000	15,386	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2,451,323	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	206,286,683			1,045,945	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150104 Component CCN: 15S104	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/29/2014 8:52 am
Title XVIII		Subprovider - LPF	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01 05501 ULTRA SOUND	0	0	0	0	0	55.01
57.00 05700 CT SCAN	0	0	0	0	0	57.00
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
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
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01 06701 AUDIOLOGY	0	0	0	0	0	67.01
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01 06901 CARDIOLOGY	0	0	0	0	0	69.01
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
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02 09002 CLINIC	0	0	0	0	0	90.02
90.03 09003 DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04 09004 ENT CLINIC	0	0	0	0	0	90.04
90.05 09005 SURGERY CLINIC	0	0	0	0	0	90.05
90.07 09007 UROLOGY CLINIC	0	0	0	0	0	90.07
90.09 09009 GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11 09011 NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12 09012 OPHTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13 09013 ALLERGY CLINIC	0	0	0	0	0	90.13
90.14 09014 WOUND CARE	0	0	0	0	0	90.14
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
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: 150104 Component CCN: 15S104	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/29/2014 8:52 am
	Title XVII I	Subprovider - IPF	PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
55.01	05501 ULTRA SOUND	0	0	55.01
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
67.01	06701 AUDIOLOGY	0	0	67.01
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
69.01	06901 RADIOLOGY	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0	90.01
90.02	09002 CLINIC	0	0	90.02
90.03	09003 DERMATOLOGY CLINIC	0	0	90.03
90.04	09004 ENT CLINIC	0	0	90.04
90.05	09005 SURGERY CLINIC	0	0	90.05
90.07	09007 UROLOGY CLINIC	0	0	90.07
90.09	09009 GASTROENTEROLOGY CLINIC	0	0	90.09
90.11	09011 NEUROLOGY CLINIC	0	0	90.11
90.12	09012 OPHTHALMOLOGY CLINIC	0	0	90.12
90.13	09013 ALLERGY CLINIC	0	0	90.13
90.14	09014 WOUND CARE	0	0	90.14
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES			95.00
200.00	Total (lines 50-199)	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/29/2014 8:52 am
		Title XVII	Hospital	PPS
Cost Center Description				
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,288	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,288	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)		4,896	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,210	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		8,206,432	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)		8,206,432	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		8,206,432	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,305.09	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,884,249	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)		2,884,249	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150104		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1		
		Title XVIII		Hospital		PPS		
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00	
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT	2,459,064	1,502	1,637.19	590	965,942	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)						3,568,136	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						7,418,327	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)						564,679	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						272,646	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						837,325	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						6,581,002	53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)						1,392	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,305.09	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						1,816,685	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150104		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/29/2014 8:52 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	1,226,401	8,206,432	0.149444	1,816,685	271,493	90.00
91.00	Nursing School cost	0	8,206,432	0.000000	1,816,685	0	91.00
92.00	Allied health cost	0	8,206,432	0.000000	1,816,685	0	92.00
93.00	All other Medical Education	0	8,206,432	0.000000	1,816,685	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Component CCN: 15S104		Date/Time Prepared: 5/29/2014 8:52 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,075	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,075	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)		2,075	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,874	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,779,608	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)		2,779,608	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,779,608	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,339.57	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,510,354	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)		2,510,354	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150104		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
		Component CCN: 15S104				Date/Time Prepared: 5/29/2014 8:52 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					161,301		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,671,655		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)					362,450		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					11,615		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					374,065		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					2,297,590		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150104 Component CCN: 15S104		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/29/2014 8:52 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	401,325	2,779,608	0.144382	0	0	90.00
91.00	Nursing School cost	0	2,779,608	0.000000	0	0	91.00
92.00	Allied health cost	0	2,779,608	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,779,608	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/29/2014 8:52 am
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			6,288 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			6,288 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)			4,896 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)			492 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)			921 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			8,206,432 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)			8,206,432 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			8,206,432 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,305.09 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			642,104 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)			642,104 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/29/2014 8:52 am
Title XIX			Hospital	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)
42.00 NURSERY (title V & XIX only)	54,173	921	58.82	0	42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	2,459,064	1,502	1,637.19	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)				298,153	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				940,257	49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge				0.00	55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)				1,392	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,305.09	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)				1,816,685	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150104		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/29/2014 8:52 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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/29/2014 8:52 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,781,902	30.00
31.00	03100	INTENSIVE CARE UNIT		1,124,340	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.149650	2,303,354	344,697 50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.337526	593,207	200,223 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0 55.00
55.01	05501	ULTRA SOUND	0.090882	238,917	21,713 55.01
57.00	05700	CT SCAN	0.038677	1,344,466	52,000 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.123285	216,852	26,735 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.204290	716,674	146,409 59.00
60.00	06000	LABORATORY	0.170357	3,838,608	653,934 60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.238340	126,245	30,089 63.00
64.00	06400	INTRAVENOUS THERAPY	0.001212	453,143	549 64.00
66.00	06600	PHYSICAL THERAPY	0.524808	303,535	159,298 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.867070	171,163	148,410 67.00
67.01	06701	AUDIOLOGY	0.265039	0	0 67.01
68.00	06800	SPEECH PATHOLOGY	0.359185	21,938	7,880 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0 69.00
69.01	06901	CARDIOLOGY	0.171492	1,999,467	342,893 69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.486669	578,162	281,374 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.581565	1,054,320	613,156 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.071351	2,502,235	178,537 73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	0 90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0 90.01
90.02	09002	CLINIC	0.000000	0	0 90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0 90.03
90.04	09004	ENT CLINIC	0.000000	0	0 90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0 90.05
90.07	09007	UROLOGY CLINIC	0.018686	890	17 90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0 90.09
90.11	09011	NEUROLOGY CLINIC	0.001227	0	0 90.11
90.12	09012	OPHTHAMOLOGY CLINIC	0.140881	160	23 90.12
90.13	09013	ALLERGY CLINIC	0.156156	0	0 90.13
90.14	09014	WOUND CARE	0.461130	2,325	1,072 90.14
91.00	09100	EMERGENCY	0.266833	1,345,885	359,127 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.741104	0	0 92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		17,811,546	3,568,136 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		17,811,546	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3	
		Component CCN: 15S104		Date/Time Prepared: 5/29/2014 8:52 am	
		Title XVII I	Subprovider - I PF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - I PF		1,767,710	40.00
41.00	04100	SUBPROVIDER - I RF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.149650	10,587	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.337526	21,598	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	55.00
55.01	05501	ULTRA SOUND	0.090882	11,348	55.01
57.00	05700	CT SCAN	0.038677	29,950	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.123285	3,851	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.204290	3,148	59.00
60.00	06000	LABORATORY	0.170357	399,806	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.238340	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001212	3,501	64.00
66.00	06600	PHYSICAL THERAPY	0.524808	38,933	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.867070	4,742	67.00
67.01	06701	AUDIOLOGY	0.265039	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.359185	1,126	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
69.01	06901	CARDIOLOGY	0.171492	64,203	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.486669	23,369	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.581565	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.071351	414,391	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	90.01
90.02	09002	CLINIC	0.000000	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	90.05
90.07	09007	UROLOGY CLINIC	0.018686	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.001227	0	90.11
90.12	09012	OPHTHALMOLOGY CLINIC	0.140881	0	90.12
90.13	09013	ALLERGY CLINIC	0.156156	0	90.13
90.14	09014	WOUND CARE	0.461130	6	90.14
91.00	09100	EMERGENCY	0.266833	15,386	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.741104	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,045,945	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)		1,045,945	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/29/2014 8:52 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,443,593	30.00
31.00	03100	INTENSIVE CARE UNIT		133,253	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		268,598	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.149650	317,011	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.337526	34,426	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	55.00
55.01	05501	ULTRA SOUND	0.090882	20,594	55.01
57.00	05700	CT SCAN	0.038677	110,778	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.123285	15,877	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.204290	161	59.00
60.00	06000	LABORATORY	0.170357	410,096	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.238340	26,899	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001212	78,747	64.00
66.00	06600	PHYSICAL THERAPY	0.524808	15,060	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.867070	7,648	67.00
67.01	06701	AUDIOLOGY	0.265039	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.359185	1,285	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
69.01	06901	CARDIOLOGY	0.171492	130,736	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.486669	142,989	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.581565	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.071351	288,176	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	90.01
90.02	09002	CLINIC	0.000000	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	90.05
90.07	09007	UROLOGY CLINIC	0.018686	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.001227	0	90.11
90.12	09012	OPHTHAMOLOGY CLINIC	0.140881	0	90.12
90.13	09013	ALLERGY CLINIC	0.156156	0	90.13
90.14	09014	WOUND CARE	0.461130	0	90.14
91.00	09100	EMERGENCY	0.266833	101,219	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.741104	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,701,702	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		1,701,702	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/29/2014 8:52 am
		Title XVII	Hospital	PPS
		0	1.00	2.00
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013 (see instructions)		3,961,077	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		1,110,511	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)		11,701	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)		64.19	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.16	30.00
31.00	Percentage of Medicaid patient days (see instructions)		25.89	31.00
32.00	Sum of lines 30 and 31		29.05	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.00	33.00
34.00	Disproportionate share adjustment (see instructions)		508,644	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/29/2014 8:52 am	
		Title XVII	Hospital	PPS	
		0	Prior to October 1	On/After October 1	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)			9,046,380,143	35.00
35.01	Factor 3 (see instructions)			0.000059567	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			538,863	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			135,823	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		135,823		36.00
Additional payment for high percentage of ESRD beneficiary discharges					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)			0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)			0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)			0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41)			0	46.00
47.00	Subtotal (see instructions)		5,727,756		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)		5,727,756		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		407,625		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)		6,135,381		59.00
60.00	Primary payer payments			3,713	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		6,131,668		61.00
62.00	Deductibles billed to program beneficiaries		713,784		62.00
63.00	Coinurance billed to program beneficiaries		6,512		63.00
64.00	Allowable bad debts (see instructions)		117,640		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		76,466		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		90,704		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		5,487,838		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 AMOUNT			-861	70.00
70.92	Bundled Model 1 discount amount			0	70.92
70.93	HVBP incentive payment (see instructions)			14,952	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)	2012		523,513	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)	2013		112,406	70.97
70.98	Low Volume Payment-3			0	70.98

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/29/2014 8:52 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)		6,137,848		71.00
71.01	Sequestration adjustment (see instructions)		92,682		71.01
72.00	Interim payments		6,014,767		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		30,399		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		60,000		75.00
TO BE COMPLETED BY CONTRACTOR					
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the Time Value of Money		0.00		94.00
95.00	Time Value of Money for operating expenses(see instructions)		0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)		0		96.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet DSH Date/Time Prepared: 5/29/2014 8:52 am
		Title XVII	Hospital	PPS

	Original mcx Values	Adjusted mcx Values	HFS Look Up	Override Value	Revised Value	
	1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE						
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	3.16	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	25.89	0.00		25.89	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	29.05	0.00		25.89	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	Urban			Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	64.19	0.00		64.19	5.00
6.00	Disproportionate Share Payment Percentage (transfer to Worksheet E, Part A, line 33)	12.00	0.00		10.57	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes			Yes	7.00
8.00	S-2, Line 22	Yes			Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No			No	9.00
10.00	S-2, Line 45	No			No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 geater than -0-)	Yes			Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No			No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS						
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	528	0		528	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	510	0		510	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0		0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0		0	18.00
18.01	N/A	0	0		0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	898	0		898	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0		0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	1,936	0		1,936	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	7,319	0		7,319	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	74	0		74	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	85	0		85	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0		0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	7,478	0		7,478	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	25.89	0.00		25.89	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet DSH Date/Time Prepared: 5/29/2014 8:52 am
		Title XVII I	Hospital	PPS

		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	13.18		0.00	True	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False	29.00
30.00	Line 28 or 29 as applicable		13.18		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		13.18		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE							
32.00	Does the hospital qualify under the Pickle amendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, Line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet DSH Date/Time Prepared: 5/29/2014 8:52 am
		Title XVII	Hospital	PPS
		Revised Percentage 6.00		
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE				
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	10.57		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00		29.00
30.00	Line 28 or 29 as applicable	10.57		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	10.57		31.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150104

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/29/2014 8:52 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	3,961,077	0	3,961,077	0	3,961,077	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013	1.02	1,110,511	0	0	1,110,511	1,110,511	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	11,701	0	11,701	0	11,701	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
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	Amount from Worksheet E Part A, line 27 (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	508,644	0	475,329	33,315	508,644	11.00
11.01	Uncompensated care payments	36.00	135,823	0	0	135,823	135,823	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	5,727,756	0	4,448,107	1,279,649	5,727,756	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	5,727,756	0	4,448,107	1,279,649	5,727,756	15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50.00	407,625	0	318,860	88,765	407,625	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	4,766,967	1,368,414	6,135,381	19.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150104

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/29/2014 8:52 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	403,321	0	314,556	88,765	403,321	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	4,304	0	4,304	0	4,304	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	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (line 20 times line 24)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	12.00	407,625	0	318,860	88,765	407,625	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				0.109821	0.082143		27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.96			523,513		523,513	28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.97				112,406	112,406	29.00
100.00	Transfer low volume adjustments to W/S E Part A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/29/2014 8:52 am
		Title XVII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		3,947	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		7,009,430	2.00
3.00	PPS payments		6,192,648	3.00
4.00	Outlier payment (see instructions)		839	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)		3,947	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		28,015	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)		28,015	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		28,015	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		24,068	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)		3,947	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		6,193,487	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		59	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,443,831	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)		4,753,544	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)		4,753,544	30.00
31.00	Primary payer payments		821	31.00
32.00	Subtotal (line 30 minus line 31)		4,752,723	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		139,345	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		90,574	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		115,602	36.00
37.00	Subtotal (see instructions)		4,843,297	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-21	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)		4,843,318	40.00
40.01	Sequestration adjustment (see instructions)		73,134	40.01
41.00	Interim payments		4,736,969	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		33,215	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00
				Overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)		0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150104

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

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2014 8:52 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		5,831,179		4,676,943	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	07/31/2013	71,182	07/31/2013	60,026	3.01
3.02		12/31/2013	112,406		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)		183,588		60,026	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)		6,014,767		4,736,969	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		30,399		33,215	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		6,045,166		4,770,184	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: 150104
Component CCN: 15S104

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

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2014 8:52 am
PPS

Title XVIII

Subprovider -
IPF

		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		1,518,146		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)		1,518,146		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		141		0	6.02
7.00	Total Medicare program liability (see instructions)		1,518,005		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: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet E-1 Part II Date/Time Prepared: 5/29/2014 8:52 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14		2,134	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12		2,800	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2		520	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12		6,398	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200		227,672,930	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20		5,762,415	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)		877,262	8.00
9.00	Sequestration adjustment amount (see instructions)		17,545	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		859,717	10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)		854,617	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)		5,100	32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			0108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150104 Component CCN: 15S104	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part II Date/Time Prepared: 5/29/2014 8:52 am
		Title XVII I	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			1,680,443 1.00
2.00	Net IPF PPS Outlier Payments			8,180 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program". (see inst.)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program". (see inst.)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			5.684932 9.00
10.00	Teaching Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			1,688,623 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 15.00
16.00	Subtotal (see instructions)			1,688,623 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			1,688,623 18.00
19.00	Deductibles			144,148 19.00
20.00	Subtotal (line 18 minus line 19)			1,544,475 20.00
21.00	Coinsurance			3,256 21.00
22.00	Subtotal (line 20 minus line 21)			1,541,219 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			0 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 25.00
26.00	Subtotal (sum of lines 22 and 24)			1,541,219 26.00
27.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER AMOUNT			59 30.00
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			1,541,278 31.00
31.01	Sequestration adjustment (see instructions)			23,273 31.01
32.00	Interim payments			1,518,146 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33			-141 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			8,180 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: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2014 8:52 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		940,257		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)		940,257	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)		940,257	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		1,712,191		8.00
9.00	Ancillary service charges		1,701,702	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)		3,413,893	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		3,413,893	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		2,473,636	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)		940,257	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		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)		940,257	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		940,257	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)		940,257	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		940,257	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)		940,257	0	40.00
41.00	Interim payments		1,301,925	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		-361,668	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: 150104

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

Worksheet G

Date/Time Prepared:
5/29/2014 8:52 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	43,782,006	0	0	0	1.00
2.00	Temporary investments	14,544,473	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	42,301,338	0	0	0	4.00
5.00	Other receivable	876,886	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-28,932,105	0	0	0	6.00
7.00	Inventory	2,235,576	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	3,095,000	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)	77,903,174	0	0	0	11.00
FIXED ASSETS						
12.00	Land	7,721,719	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	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	116,050,009	0	0	0	23.00
24.00	Accumulated depreciation	-49,387,274	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)	74,384,454	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	11,092,055	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	11,092,055	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	163,379,683	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,367,084	0	0	0	37.00
38.00	Salaries, wages, and fees payable	6,605,679	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	7,197,743	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	17,170,506	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	64,502,298	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	64,502,298	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	81,672,804	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	81,706,879	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)	81,706,879	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	163,379,683	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150104

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

Worksheet G-1

Date/Time Prepared:
5/29/2014 8:52 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		78,693,561		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		3,013,318		0		2.00
3.00	Total (sum of line 1 and line 2)		81,706,879		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)		81,706,879		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)		81,706,879		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: 150104

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/29/2014 8:52 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	14,088,341		14,088,341	1.00
2.00	SUBPROVIDER - IPF	1,961,294		1,961,294	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	16,049,635		16,049,635	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,146,548		3,146,548	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)	3,146,548		3,146,548	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	19,196,183		19,196,183	17.00
18.00	Ancillary services	36,081,216	147,254,400	183,335,616	18.00
19.00	Outpatient services	2,616,054	29,675,304	32,291,358	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 PRIVATE OFFICE, MISC	1,632	31,315,461	31,317,093	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	57,895,085	208,245,165	266,140,250	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		93,437,314		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		93,437,314		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150104

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

Worksheet G-3

Date/Time Prepared:
5/29/2014 8:52 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	266,140,250	1.00
2.00	Less contractual allowances and discounts on patients' accounts	170,980,325	2.00
3.00	Net patient revenues (line 1 minus line 2)	95,159,925	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	93,437,314	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,722,611	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING AND NONOPERATING RE	1,287,517	24.00
25.00	Total other income (sum of lines 6-24)	1,287,517	25.00
26.00	Total (line 5 plus line 25)	3,010,128	26.00
27.00	MISC	-3,190	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-3,190	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,013,318	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150104	Period: From 01/01/2013 To 12/31/2013	Worksheet L Parts I-III Date/Time Prepared: 5/29/2014 8:52 am
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		403,321	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		4,304	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)		17.76	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		0	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		407,625	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00