

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: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet S Parts I-III Date/Time Prepared: 5/28/2014 11:19 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: 5/28/2014 Time: 11:19 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 IU HEALTH STARKE MEMORIAL HOSPITAL (150102) for the cost reporting period beginning 01/01/2013 and ending 12/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

 VICE PRESIDENT OF FINANCE
 Title

 05/28/2014
 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	33,671	22,177	72,765	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	52	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
200.00 Total	0	33,723	22,177	72,765	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/28/2014 10:17 am
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1.00 Hospital and Hospital Health Care Complex Address:	2.00 Street: 102 EAST CULVER RD	3.00 PO Box:	4.00 State: IN	5.00 Zip Code: 46534	6.00 County: STARKE	7.00	8.00	9.00	10.00
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Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
					V	XVIII	XIX

3.00 Hospital and Hospital-Based Component Identification:									3.00
3.00 Hospital	IU HEALTH STARKE MEMORIAL HOSPITAL	150102	23844	1	07/11/1966	N	P	P	3.00
4.00 Subprovider - IPF									4.00
5.00 Subprovider - IRF									5.00
6.00 Subprovider - (Other)									6.00
7.00 Swing Beds - SNF	IU HEALTH STARKE MEMORIAL SWING BED	15U102	23844		09/06/1989	N	P	N	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 - FOHC									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)					2					21.00

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

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
								1.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	144	29	0	0	17	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: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/28/2014 10:17 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.	2			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.	2			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.	1			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.	01/01/2013	12/31/2013		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	XVII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		

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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 Nonprovi der Si te	Unweighted FTEs in Hospi tal	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	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	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: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/28/2014 10:17 am																																																																																																																						
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		1.00	2.00	3.00																																																																																																																						
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		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))																																																																																																																				
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(see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)</td> <td></td> <td></td> <td>0</td> </tr> <tr> <td colspan="6">Inpatient Rehabilitation Facility PPS</td> </tr> <tr> <td>75.00</td> <td>Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.</td> <td></td> <td></td> <td>N</td> </tr> <tr> <td>76.00</td> <td>If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. 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(see instructions) Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td></td> <td>Y</td> </tr> <tr> <td>93.00</td> <td>Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>N</td> </tr> <tr> <td>94.00</td> <td>Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>N</td> </tr> <tr> <td>95.00</td> <td>If line 94 is "Y", enter the reduction percentage in the applicable column.</td> <td></td> <td>0.00</td> <td>0.00</td> </tr> </tbody> </table> </td> </tr> </tbody> </table> </td></tr></tbody></table>								1.00	2.00	3.00	Inpatient Psychiatric Facility PPS					70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			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		V	XIX			
		1.00	2.00			
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00	
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N			105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	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	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00	
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	58,935	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.	Y	Y		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)	Y	15H059	140.00		
		1.00	2.00	3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141.00	Name: INDIANA UNIVERSITY HEALTH, INC	Contractor's Name: WPS		Contractor's Number: 08101		
142.00	Street: 340 WEST 10TH STREET	PO Box:				
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46202		
				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		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00		
		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	N	
156.00	Subprovider - IPF	N	N	N	N	
157.00	Subprovider - IRF	N	N	N	N	
158.00	SUBPROVIDER					
159.00	SNF	N	N	N	N	
160.00	HOME HEALTH AGENCY	N	N	N	N	
161.00	CMHC		N	N	N	
				1.00		
Multi campus						
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N		165.00		
		Name	County	State	Zip Code	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		
				Begining	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: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/28/2014 10:17 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)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	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.		Y		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: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/28/2014 10:17 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.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA		UTTER	
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH			
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-962-1093		RUTTER@IUHEALTH.ORG	

		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-COST REPORTING	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150102

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

Worksheet S-3
Part I
Date/Time Prepared:
5/28/2014 10:17 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi si ts / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	50	18,099	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)		50	18,099	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	604	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						13.00
14.00 Total (see instructions)		50	18,703	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		50				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150102

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

Worksheet S-3
Part I
Date/Time Prepared:
5/28/2014 10:17 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,263	153	1,733			1.00
2.00 HMO and other (see instructions)	89	17				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	50	0	56			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)	1,313	153	1,789			7.00
8.00 INTENSIVE CARE UNIT	87	20	226			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)	1,400	173	2,015	0.00	132.94	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	132.94	27.00
28.00 Observation Bed Days		490	1,376			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			13			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150102

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

Worksheet S-3
Part I
Date/Time Prepared:
5/28/2014 10:17 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	352	61	546	1.00
2.00 HMO and other (see instructions)				25			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		352	61	546	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 150102		Period: From 01/01/2013 To 12/31/2013		Worksheet S-3 Part II Date/Time Prepared: 5/28/2014 10:17 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	6,877,813	0	6,877,813	276,573.00	24.87	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)		65,251	0	65,251	4,075.00	16.01	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor (see instructions)		0	0	0	0.00	0.00	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		398,203	0	398,203	2,575.57	154.61	13.00
14.00	Home office salaries & wage-related costs		369,086	0	369,086	7,406.00	49.84	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)		1,574,336	0	1,574,336			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		15,222	0	15,222			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/FOHC)		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	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	897,895	0	897,895	39,527.00	22.72	27.00
28.00	Administrative & General under contract (see inst.)		64,287	0	64,287	284.00	226.36	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	316,776	0	316,776	16,436.00	19.27	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	165,492	0	165,492	14,734.00	11.23	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	213,934	-135,678	78,256	5,289.00	14.80	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	135,678	135,678	9,169.00	14.80	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	378,950	0	378,950	12,087.00	31.35	38.00
39.00	Central Services and Supply	14.00	78,821	0	78,821	4,178.00	18.87	39.00
40.00	Pharmacy	15.00	198,286	0	198,286	5,626.00	35.24	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150102

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

Worksheet S-3
Part II
Date/Time Prepared:
5/28/2014 10:17 am

		Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
42.00	Soci al Servi ce	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Servi ce	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150102

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

Worksheet S-3
Part III
Date/Time Prepared:
5/28/2014 10:17 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	6,942,100	0	6,942,100	276,857.00	25.07	1.00
2.00	Excluded area salaries (see instructions)	65,251	0	65,251	4,075.00	16.01	2.00
3.00	Subtotal salaries (line 1 minus line 2)	6,876,849	0	6,876,849	272,782.00	25.21	3.00
4.00	Subtotal other wages & related costs (see inst.)	767,289	0	767,289	9,981.57	76.87	4.00
5.00	Subtotal wage-related costs (see inst.)	1,574,336	0	1,574,336	0.00	22.89	5.00
6.00	Total (sum of lines 3 thru 5)	9,218,474	0	9,218,474	282,763.57	32.60	6.00
7.00	Total overhead cost (see instructions)	2,314,441	0	2,314,441	107,330.00	21.56	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet S-3 Part IV Date/Time Prepared: 5/28/2014 10:17 am
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	146,392	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)	763,658	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	64,609	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	12,141	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)	22,171	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	50,140	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	513,747	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	1,095	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	15,604	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	1,589,557	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet S-3 Part V Date/Time Prepared: 5/28/2014 10:17 am
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		0	0 1.00
2.00	Hospital		0	0 2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)		0	0 5.00
6.00	Swing Beds - SNF		0	0 6.00
7.00	Swing Beds - NF		0	0 7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other		0	0 18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 150102

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

Worksheet S-7

Date/Time Prepared:
5/28/2014 10:17 am

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.			2.00

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1.00	2.00	3.00	4.00	
3.00	RUX	0	0	0	3.00
4.00	RUL	0	0	0	4.00
5.00	RVX	0	0	0	5.00
6.00	RVL	0	0	0	6.00
7.00	RHX	0	0	0	7.00
8.00	RHL	0	0	0	8.00
9.00	RMX	0	0	0	9.00
10.00	RML	0	0	0	10.00
11.00	RLX	0	0	0	11.00
12.00	RUC	0	0	0	12.00
13.00	RUB	0	0	0	13.00
14.00	RUA	0	0	0	14.00
15.00	RVC	0	14	14	15.00
16.00	RVB	0	0	0	16.00
17.00	RVA	0	0	0	17.00
18.00	RHC	0	0	0	18.00
19.00	RHB	0	0	0	19.00
20.00	RHA	0	0	0	20.00
21.00	RMC	0	0	0	21.00
22.00	RMB	0	0	0	22.00
23.00	RMA	0	0	0	23.00
24.00	RLB	0	0	0	24.00
25.00	RLA	0	0	0	25.00
26.00	ES3	0	0	0	26.00
27.00	ES2	0	0	0	27.00
28.00	ES1	0	0	0	28.00
29.00	HE2	0	0	0	29.00
30.00	HE1	0	0	0	30.00
31.00	HD2	0	0	0	31.00
32.00	HD1	0	13	13	32.00
33.00	HC2	0	0	0	33.00
34.00	HC1	0	16	16	34.00
35.00	HB2	0	0	0	35.00
36.00	HB1	0	0	0	36.00
37.00	LE2	0	0	0	37.00
38.00	LE1	0	0	0	38.00
39.00	LD2	0	0	0	39.00
40.00	LD1	0	0	0	40.00
41.00	LC2	0	0	0	41.00
42.00	LC1	0	0	0	42.00
43.00	LB2	0	0	0	43.00
44.00	LB1	0	0	0	44.00
45.00	CE2	0	0	0	45.00
46.00	CE1	0	0	0	46.00
47.00	CD2	0	0	0	47.00
48.00	CD1	0	0	0	48.00
49.00	CC2	0	0	0	49.00
50.00	CC1	0	0	0	50.00
51.00	CB2	0	0	0	51.00
52.00	CB1	0	0	0	52.00
53.00	CA2	0	0	0	53.00
54.00	CA1	0	7	7	54.00
55.00	SE3	0	0	0	55.00
56.00	SE2	0	0	0	56.00
57.00	SE1	0	0	0	57.00
58.00	SSC	0	0	0	58.00
59.00	SSB	0	0	0	59.00
60.00	SSA	0	0	0	60.00
61.00	IB2	0	0	0	61.00
62.00	IB1	0	0	0	62.00
63.00	IA2	0	0	0	63.00
64.00	IA1	0	0	0	64.00
65.00	BB2	0	0	0	65.00
66.00	BB1	0	0	0	66.00
67.00	BA2	0	0	0	67.00
68.00	BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 150102

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

Worksheet S-7

Date/Time Prepared:
5/28/2014 10:17 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	50	50	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
201.00	SNF SERVICES	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).		23844	23844	201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		0	0.00		202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		0			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet S-10 Date/Time Prepared: 5/28/2014 10:17 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)		0.297595		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		4,765,769		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		Y		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0		5.00
6.00	Medicaid charges		10,953,872		6.00
7.00	Medicaid cost (line 1 times line 6)		3,259,818		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0		8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0		9.00
10.00	Stand-alone SCHIP charges		0		10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0		11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		217,247		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		1,448,431		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		431,046		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)		213,799		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		20,770		18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		213,799		19.00
				1.00	
				2.00	
				3.00	
				4.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	2,306,221	539,507	2,845,728	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	686,320	160,555	846,875	21.00
22.00	Partial payment by patients approved for charity care	113,066	52,470	165,536	22.00
23.00	Cost of charity care (line 21 minus line 22)	573,254	108,085	681,339	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		2,285,210		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		70,508		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		2,214,702		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		659,084		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,340,423		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,554,222		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 150102		Period: From 01/01/2013 To 12/31/2013		Worksheet A	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	33,000	33,000	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	5,867	5,867	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	651,188	651,188	0	651,188	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	897,895	2,889,949	3,787,844	-47,230	3,740,614	5.00
7.00	00700	OPERATION OF PLANT	316,776	654,900	971,676	-961	970,715	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	165,492	97,154	262,646	-2,120	260,526	9.00
10.00	01000	DIETARY	213,934	117,655	331,589	-210,460	121,129	10.00
11.00	01100	CAFETERIA	0	0	0	210,009	210,009	11.00
13.00	01300	NURSING ADMINISTRATION	378,950	39,666	418,616	0	418,616	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	78,821	32,138	110,959	556,530	667,489	14.00
15.00	01500	PHARMACY	198,286	605,876	804,162	-508,008	296,154	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	345,854	345,854	0	345,854	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	925,017	190,466	1,115,483	-49,999	1,065,484	30.00
31.00	03100	INTENSIVE CARE UNIT	192,371	22,784	215,155	-4,129	211,026	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	521,873	608,706	1,130,579	-388,193	742,386	50.00
53.00	05300	ANESTHESIOLOGY	0	330,531	330,531	-22,543	307,988	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	908,516	1,409,214	2,317,730	-35,886	2,281,844	54.00
57.00	05700	CT SCAN	0	207,257	207,257	-19,910	187,347	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	55,032	184,542	239,574	-436	239,138	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	421,321	735,820	1,157,141	23,805	1,180,946	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	46,464	46,464	-46,464	0	62.00
65.00	06500	RESPIRATORY THERAPY	329,271	74,791	404,062	-10,444	393,618	65.00
66.00	06600	PHYSICAL THERAPY	137,921	21,217	159,138	-1,184	157,954	66.00
67.00	06700	OCCUPATIONAL THERAPY	113,027	9,215	122,242	-86	122,156	67.00
68.00	06800	SPEECH PATHOLOGY	53,629	3,926	57,555	-13	57,542	68.00
69.00	06900	ELECTROCARDIOLOGY	81,488	32,380	113,868	-210	113,658	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	109,458	109,458	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	63,827	63,827	0	63,827	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	513,464	513,464	73.00
76.97	07697	CARDIAC REHAB	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	822,942	2,539,066	3,362,008	-103,514	3,258,494	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,812,562	11,914,586	18,727,148	343	18,727,491	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	WELLNESS CENTER	44,614	12,254	56,868	-66	56,802	193.01
194.00	07950	OTHER NRCC	20,637	72,244	92,881	-277	92,604	194.00
200.00		TOTAL (SUM OF LINES 118-199)	6,877,813	11,999,084	18,876,897	0	18,876,897	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150102

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

Worksheet A
Date/Time Prepared:
5/28/2014 10:17 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	55,917	88,917	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	27,986	33,853	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,596,004	2,247,192	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,059,102	6,799,716	5.00
7.00	00700	OPERATION OF PLANT	111,121	1,081,836	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	8.00
9.00	00900	HOUSEKEEPING	16,594	277,120	9.00
10.00	01000	DIETARY	0	121,129	10.00
11.00	01100	CAFETERIA	-70,679	139,330	11.00
13.00	01300	NURSING ADMINISTRATION	-855	417,761	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-6,649	660,840	14.00
15.00	01500	PHARMACY	-2,254	293,900	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	345,854	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,065,484	30.00
31.00	03100	INTENSIVE CARE UNIT	0	211,026	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	742,386	50.00
53.00	05300	ANESTHESIOLOGY	-305,473	2,515	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,281,844	54.00
57.00	05700	CT SCAN	0	187,347	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	239,138	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-2,602	1,178,344	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	-22,525	371,093	65.00
66.00	06600	PHYSICAL THERAPY	0	157,954	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	122,156	67.00
68.00	06800	SPEECH PATHOLOGY	0	57,542	68.00
69.00	06900	ELECTROCARDIOLOGY	-384	113,274	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	109,458	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	63,827	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	513,464	73.00
76.97	07697	CARDIAC REHAB	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-2,029,115	1,229,379	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,426,188	21,153,679	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	WELLNESS CENTER	0	56,802	193.01
194.00	07950	OTHER NRCC	0	92,604	194.00
200.00		TOTAL (SUM OF LINES 118-199)	2,426,188	21,303,085	200.00

RECLASSIFICATIONS

Provider CCN: 150102

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

Worksheet A-6

Date/Time Prepared:
5/28/2014 10:17 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - RENT						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	33,000	1.00	
	TOTALS		0	33,000		
B - CAFETERIA						
1.00	CAFETERIA	11.00	135,678	74,331	1.00	
	TOTALS		135,678	74,331		
C - DRUGS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	513,464	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	
	TOTALS		0	513,464		
D - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	665,988	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	
	TOTALS		0	665,988		
E - BILLABLE MED SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	109,458	1.00	
	TOTALS		0	109,458		
F - BLOOD ADMINISTRATION						
1.00	LABORATORY	60.00	0	46,464	1.00	
	TOTALS		0	46,464		
H - INTEREST EXPENSE						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,867	1.00	
	TOTALS		0	5,867		
500.00	Grand Total: Increases		135,678	1,448,572	500.00	

RECLASSIFICATIONS

Provider CCN: 150102

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

Worksheet A-6

Date/Time Prepared:
5/28/2014 10:17 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - RENT							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	33,000	10		1.00
	TOTALS		0	33,000			
B - CAFETERIA							
1.00	DIETARY	10.00	135,678	74,331	0		1.00
	TOTALS		135,678	74,331			
C - DRUGS							
1.00	PHARMACY	15.00	0	506,748	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	989	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	134	0		3.00
4.00	OPERATING ROOM	50.00	0	5,140	0		4.00
5.00	EMERGENCY	91.00	0	453	0		5.00
	TOTALS		0	513,464			
D - MEDICAL SUPPLIES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,363	0		1.00
2.00	OPERATION OF PLANT	7.00	0	961	0		2.00
3.00	HOUSEKEEPING	9.00	0	2,120	0		3.00
4.00	DIETARY	10.00	0	451	0		4.00
5.00	PHARMACY	15.00	0	1,260	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	49,010	0		6.00
7.00	INTENSIVE CARE UNIT	31.00	0	3,995	0		7.00
8.00	OPERATING ROOM	50.00	0	383,053	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	22,543	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	35,886	0		10.00
11.00	CT SCAN	57.00	0	19,910	0		11.00
12.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	436	0		12.00
13.00	LABORATORY	60.00	0	22,659	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	10,444	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	1,184	0		15.00
16.00	OCCUPATIONAL THERAPY	67.00	0	86	0		16.00
17.00	SPEECH PATHOLOGY	68.00	0	13	0		17.00
18.00	ELECTROCARDIOLOGY	69.00	0	210	0		18.00
19.00	EMERGENCY	91.00	0	103,061	0		19.00
20.00	WELLNESS CENTER	193.01	0	66	0		20.00
21.00	OTHER NRCC	194.00	0	277	0		21.00
	TOTALS		0	665,988			
E - BILLABLE MED SUPPLIES							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	109,458	0		1.00
	TOTALS		0	109,458			
F - BLOOD ADMINISTRATION							
1.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	46,464	0		1.00
	TOTALS		0	46,464			
H - INTEREST EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,867	11		1.00
	TOTALS		0	5,867			
500.00	Grand Total: Decreases		135,678	1,448,572			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150102

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

Worksheet A-7
Part I
Date/Time Prepared:
5/28/2014 10:17 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	142,789	0	0	0	0	1.00
2.00	Land Improvements	4,448	0	0	0	0	2.00
3.00	Buildings and Fixtures	1,509,571	0	0	0	0	3.00
4.00	Building Improvements	4,817,846	155,931	0	155,931	2,946	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	8,355,504	228,163	0	228,163	41,935	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	14,830,158	384,094	0	384,094	44,881	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	14,830,158	384,094	0	384,094	44,881	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	142,789	0				1.00
2.00	Land Improvements	4,448	0				2.00
3.00	Buildings and Fixtures	1,509,571	0				3.00
4.00	Building Improvements	4,970,831	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	8,541,732	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	15,169,371	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	15,169,371	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150102

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

Worksheet A-7
Part II
Date/Time Prepared:
5/28/2014 10:17 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	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150102

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

Worksheet A-7
Part III
Date/Time Prepared:
5/28/2014 10:17 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	CAP REL COSTS-BLDG & FIXT	6,627,639	0	6,627,639	0.436909	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,541,732	0	8,541,732	0.563091	0	2.00
3.00	Total (sum of lines 1-2)	15,169,371	0	15,169,371	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	33,000	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	33,000	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	55,917	0	0	0	88,917	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	33,853	0	0	0	33,853	2.00
3.00	Total (sum of lines 1-2)	89,770	0	0	0	122,770	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150102

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

Worksheet A-8

Date/Time Prepared:
5/28/2014 10:17 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-2,439	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00		2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-2,398,503			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	5,372,199			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-73,002	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employee and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients	B	-6,649	CENTRAL SERVICES & SUPPLY	14.00	0	16.00
17.00 Sale of drugs to other than patients	B	-2,254	PHARMACY	15.00	0	17.00
18.00 Sale of medical records and abstracts		0		0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00 MEDICAID ASSESSMENT FEE	A	-335,933	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00 MISCELLANEOUS INCOME	B	-16,685	ADMINISTRATIVE & GENERAL	5.00	0	34.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150102

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

Worksheet A-8

Date/Time Prepared:
5/28/2014 10:17 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
35.00 MISCELLANEOUS INCOME	B	-855	NURSING ADMINISTRATION	13.00	0	35.00
36.00 MARKETING & ADVERTISING	A	-67,853	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00 PATIENT PHONES	A	-11,576	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00 ADMISSIONS TIME FOR PATIENT PHONES	A	-28,252	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00 NON-ALLOWABLE LOBBYING EXPENSE	A	-2,010	ADMINISTRATIVE & GENERAL	5.00	0	39.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		2,426,188				50.00

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

Provider CCN: 150102

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

Worksheet A-8-1

Date/Time Prepared:
5/28/2014 10:17 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	ALLOCATION FROM HO REPORT	58,356	0
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	ALLOCATION FROM HO REPORT	27,986	0
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	ALLOCATION FROM HO REPORT	163,344	0
4.00	5.00	ADMINISTRATIVE & GENERAL	ALLOCATION FROM HO REPORT	579,038	293,866
4.01	7.00	OPERATION OF PLANT	ALLOCATION FROM HO REPORT	111,121	0
4.02	9.00	HOUSEKEEPING	ALLOCATION FROM HO REPORT	16,594	0
4.03	11.00	CAFETERIA	ALLOCATION FROM HO REPORT	2,323	0
4.04	60.00	LABORATORY	ALLOCATION FROM HO REPORT	281,755	281,755
4.05	4.00	EMPLOYEE BENEFITS DEPARTMENT	LAPORTE ALLOCATION	2,082,326	649,666
4.06	5.00	ADMINISTRATIVE & GENERAL	LAPORTE ALLOCATION	3,410,618	135,975
4.07	15.00	PHARMACY	LAPORTE ALLOCATION	49,581	49,581
4.08	16.00	MEDICAL RECORDS & LIBRARY	LAPORTE ALLOCATION	345,000	345,000
5.00	0			7,128,042	1,755,843

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

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

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

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

6.00	B	0.00	IU HEALTH, INC	100.00	6.00
7.00	B	0.00	LAPORTE REGIONA	100.00	7.00
8.00		0.00		0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 150102

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

Worksheet A-8-1

Date/Time Prepared:
5/28/2014 10:17 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	58,356	11		1.00
2.00	27,986	11		2.00
3.00	163,344	0		3.00
4.00	285,172	0		4.00
4.01	111,121	0		4.01
4.02	16,594	0		4.02
4.03	2,323	0		4.03
4.04	0	0		4.04
4.05	1,432,660	0		4.05
4.06	3,274,643	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
5.00	5,372,199			5.00

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

Related Organization(s) and/or Home Office	Type of Business		
	6.00		

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	HEALTH SYSTEM		6.00
7.00	HEALTH SYSTEM		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150102

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

Worksheet A-8-2

Date/Time Prepared:
5/28/2014 10:17 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	81,734	30,731	51,003	159,800	564	1.00
2.00	53.00	ANESTHESIOLOGY	305,473	305,473	0	0	0	2.00
3.00	60.00	LABORATORY	3,524	1,524	2,000	159,800	12	3.00
4.00	65.00	RESPIRATORY THERAPY	22,525	22,525	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	384	384	0	0	0	5.00
6.00	91.00	EMERGENCY	2,182,769	1,837,568	345,200	159,800	2,000	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			2,596,409	2,198,205	398,203		2,576	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	43,330	2,167	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	922	46	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	153,654	7,683	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			197,906	9,896	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	43,330	7,673	38,404	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	305,473	2.00
3.00	60.00	LABORATORY	0	922	1,078	2,602	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	22,525	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	384	5.00
6.00	91.00	EMERGENCY	0	153,654	191,546	2,029,115	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	197,906	200,297	2,398,503	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150102

Period:
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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	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	88,917	88,917			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	33,853		33,853		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,247,192	288	110	2,247,590	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	6,799,716	9,251	3,522	293,421	5.00
7.00 00700	OPERATION OF PLANT	1,081,836	28,592	10,883	103,519	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	362	138	0	8.00
9.00 00900	HOUSEKEEPING	277,120	345	132	54,081	9.00
10.00 01000	DIETARY	121,129	890	339	25,573	10.00
11.00 01100	CAFETERIA	139,330	1,544	588	44,338	11.00
13.00 01300	NURSING ADMINISTRATION	417,761	77	29	123,836	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	660,840	1,415	539	25,758	14.00
15.00 01500	PHARMACY	293,900	560	213	64,797	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	345,854	1,204	458	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,065,484	8,625	3,284	302,287	30.00
31.00 03100	INTENSIVE CARE UNIT	211,026	618	235	62,865	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	742,386	6,834	2,602	170,542	50.00
53.00 05300	ANESTHESIOLOGY	2,515	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,281,844	4,409	1,679	296,892	54.00
57.00 05700	CT SCAN	187,347	387	147	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	239,138	361	138	17,984	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	1,178,344	2,033	774	137,683	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
65.00 06500	RESPIRATORY THERAPY	371,093	2,277	867	107,602	65.00
66.00 06600	PHYSICAL THERAPY	157,954	1,619	616	45,071	66.00
67.00 06700	OCCUPATIONAL THERAPY	122,156	233	89	36,936	67.00
68.00 06800	SPEECH PATHOLOGY	57,542	233	89	17,525	68.00
69.00 06900	ELECTROCARDIOLOGY	113,274	449	171	26,629	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	109,458	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	63,827	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	513,464	0	0	0	73.00
76.97 07697	CARDIAC REHAB	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	1,229,379	2,830	1,078	268,928	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	21,153,679	75,436	28,720	2,226,267	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	225	86	0	190.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
193.01 19301	WELLNESS CENTER	56,802	0	0	14,579	193.01
194.00 07950	OTHER NRCC	92,604	13,256	5,047	6,744	194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	21,303,085	88,917	33,853	2,247,590	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150102

Period:
From 01/01/2013
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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	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,105,910				5.00
7.00	00700	OPERATION OF PLANT	613,047	1,837,877			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	250	13,107	13,857		8.00
9.00	00900	HOUSEKEEPING	166,010	12,499	0	510,187	9.00
10.00	01000	DIETARY	74,042	32,217	0	12,256	266,446
11.00	01100	CAFETERIA	92,996	55,887	0	21,260	0
13.00	01300	NURSING ADMINISTRATION	271,131	2,773	0	1,055	0
14.00	01400	CENTRAL SERVICES & SUPPLY	344,631	51,214	0	19,482	0
15.00	01500	PHARMACY	179,920	20,250	0	7,703	0
16.00	01600	MEDICAL RECORDS & LIBRARY	173,937	43,577	0	16,577	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	690,552	312,107	12,313	118,727	236,753
31.00	03100	INTENSIVE CARE UNIT	137,514	22,377	1,544	8,513	29,693
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	461,658	247,292	0	94,071	0
53.00	05300	ANESTHESIOLOGY	1,259	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,293,745	159,568	0	60,700	0
57.00	05700	CT SCAN	94,037	14,019	0	5,333	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	128,943	13,069	0	4,972	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	660,098	73,553	0	27,980	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	241,168	82,405	0	31,347	0
66.00	06600	PHYSICAL THERAPY	102,736	58,584	0	22,286	0
67.00	06700	OCCUPATIONAL THERAPY	79,789	8,434	0	3,208	0
68.00	06800	SPEECH PATHOLOGY	37,733	8,434	0	3,208	0
69.00	06900	ELECTROCARDIOLOGY	70,334	16,261	0	6,186	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	54,785	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31,946	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	256,997	0	0	0	0
76.97	07697	CARDIAC REHAB	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	751,883	102,427	0	38,964	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,011,141	1,350,054	13,857	503,828	266,446
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	156	8,130	0	3,093	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	WELLNESS CENTER	35,727	0	0	0	0
194.00	07950	OTHER NRCC	58,886	479,693	0	3,266	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)	7,105,910	1,837,877	13,857	510,187	266,446

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150102

Period:
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	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	355,943					11.00
13.00	01300	22,476	839,138				13.00
14.00	01400	7,776	0	1,111,655			14.00
15.00	01500	10,445	0	16,745	594,533		15.00
16.00	01600	0	0	0	0	581,607	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	72,071	361,814	69,292	0	44,066	30.00
31.00	03100	12,495	69,096	5,648	0	4,528	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	33,424	125,732	436,386	0	59,578	50.00
53.00	05300	0	0	31,872	0	12,939	53.00
54.00	05400	57,138	0	66,343	0	71,594	54.00
57.00	05700	0	0	36,607	0	52,769	57.00
58.00	05800	2,863	0	10,887	0	19,954	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	31,799	37,158	32,036	0	79,061	60.00
62.00	06200	0	0	0	0	0	62.00
65.00	06500	20,581	0	14,766	0	9,607	65.00
66.00	06600	10,677	0	1,674	0	10,586	66.00
67.00	06700	6,112	0	122	0	3,285	67.00
68.00	06800	2,321	0	18	0	1,183	68.00
69.00	06900	4,371	0	297	0	18,062	69.00
71.00	07100	0	0	154,756	0	5,523	71.00
72.00	07200	0	0	88,010	0	1,672	72.00
73.00	07300	0	0	0	594,533	76,540	73.00
76.97	07697	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	53,811	245,338	145,711	0	110,620	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		348,360	839,138	1,111,170	594,533	581,567	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	3,869	0	93	0	0	193.01
194.00	07950	3,714	0	392	0	40	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		355,943	839,138	1,111,655	594,533	581,607	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150102

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

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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
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				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	3,297,375	0	3,297,375	30.00
31.00	03100	566,152	0	566,152	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	2,380,505	0	2,380,505	50.00
53.00	05300	48,585	0	48,585	53.00
54.00	05400	4,293,912	0	4,293,912	54.00
57.00	05700	390,646	0	390,646	57.00
58.00	05800	438,309	0	438,309	58.00
59.00	05900	0	0	0	59.00
60.00	06000	2,260,519	0	2,260,519	60.00
62.00	06200	0	0	0	62.00
65.00	06500	881,713	0	881,713	65.00
66.00	06600	411,803	0	411,803	66.00
67.00	06700	260,364	0	260,364	67.00
68.00	06800	128,286	0	128,286	68.00
69.00	06900	256,034	0	256,034	69.00
71.00	07100	324,522	0	324,522	71.00
72.00	07200	185,455	0	185,455	72.00
73.00	07300	1,441,534	0	1,441,534	73.00
76.97	07697	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	2,950,969	0	2,950,969	91.00
92.00	09200		0		92.00
SPECIAL PURPOSE COST CENTERS					
118.00		20,516,683	0	20,516,683	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	11,690	0	11,690	190.00
193.00	19300	0	0	0	193.00
193.01	19301	111,070	0	111,070	193.01
194.00	07950	663,642	0	663,642	194.00
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		21,303,085	0	21,303,085	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150102

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

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	288	110	398	398 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	802,694	9,251	3,522	815,467	52 5.00
7.00 00700	OPERATION OF PLANT	76,281	28,592	10,883	115,756	18 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	362	138	500	0 8.00
9.00 00900	HOUSEKEEPING	1,110	345	132	1,587	10 9.00
10.00 01000	DIETARY	2,121	890	339	3,350	5 10.00
11.00 01100	CAFETERIA	0	1,544	588	2,132	8 11.00
13.00 01300	NURSING ADMINISTRATION	0	77	29	106	22 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	2,768	1,415	539	4,722	5 14.00
15.00 01500	PHARMACY	2,607	560	213	3,380	12 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	1,204	458	1,662	0 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	31,790	8,625	3,284	43,699	51 30.00
31.00 03100	INTENSIVE CARE UNIT	0	618	235	853	11 31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	69,287	6,834	2,602	78,723	30 50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	511,597	4,409	1,679	517,685	53 54.00
57.00 05700	CT SCAN	73,655	387	147	74,189	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	33,609	361	138	34,108	3 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	12,476	2,033	774	15,283	24 60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0 62.00
65.00 06500	RESPIRATORY THERAPY	3,905	2,277	867	7,049	19 65.00
66.00 06600	PHYSICAL THERAPY	6,522	1,619	616	8,757	8 66.00
67.00 06700	OCCUPATIONAL THERAPY	399	233	89	721	7 67.00
68.00 06800	SPEECH PATHOLOGY	0	233	89	322	3 68.00
69.00 06900	ELECTROCARDIOLOGY	11,565	449	171	12,185	5 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	1,458	0	0	1,458	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.97 07697	CARDIAC REHAB	0	0	0	0	0 76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	53,013	2,830	1,078	56,921	48 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	0 92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,696,857	75,436	28,720	1,801,013	394 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	225	86	311	0 190.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
193.01 19301	WELLNESS CENTER	0	0	0	0	3 193.01
194.00 07950	OTHER NRCC	24,291	13,256	5,047	42,594	1 194.00
200.00	Cross Foot Adjustments				0	0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	1,721,148	88,917	33,853	1,843,918	398 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150102

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

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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						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	815,519					5.00
7.00	00700	70,357	186,131				7.00
8.00	00800	29	1,327	1,856			8.00
9.00	00900	19,052	1,266	0	21,915		9.00
10.00	01000	8,497	3,263	0	526	15,641	10.00
11.00	01100	10,673	5,660	0	913	0	11.00
13.00	01300	31,117	281	0	45	0	13.00
14.00	01400	39,552	5,187	0	837	0	14.00
15.00	01500	20,649	2,051	0	331	0	15.00
16.00	01600	19,962	4,413	0	712	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	79,252	31,609	1,649	5,099	13,898	30.00
31.00	03100	15,782	2,266	207	366	1,743	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	52,982	25,044	0	4,041	0	50.00
53.00	05300	144	0	0	0	0	53.00
54.00	05400	148,484	16,160	0	2,607	0	54.00
57.00	05700	10,792	1,420	0	229	0	57.00
58.00	05800	14,798	1,324	0	214	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	75,756	7,449	0	1,202	0	60.00
62.00	06200	0	0	0	0	0	62.00
65.00	06500	27,678	8,346	0	1,347	0	65.00
66.00	06600	11,791	5,933	0	957	0	66.00
67.00	06700	9,157	854	0	138	0	67.00
68.00	06800	4,330	854	0	138	0	68.00
69.00	06900	8,072	1,647	0	266	0	69.00
71.00	07100	6,287	0	0	0	0	71.00
72.00	07200	3,666	0	0	0	0	72.00
73.00	07300	29,494	0	0	0	0	73.00
76.97	07697	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	86,290	10,373	0	1,674	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		804,643	136,727	1,856	21,642	15,641	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	18	823	0	133	0	190.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	4,100	0	0	0	0	193.01
194.00	07950	6,758	48,581	0	140	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		815,519	186,131	1,856	21,915	15,641	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150102		Period: From 01/01/2013 To 12/31/2013		Worksheet B Part II Date/Time Prepared: 5/28/2014 10:17 am	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	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	19,386					11.00
13.00	01300	1,224	32,795				13.00
14.00	01400	423	0	50,726			14.00
15.00	01500	569	0	764	27,756		15.00
16.00	01600	0	0	0	0	26,749	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	3,925	14,141	3,162	0	2,024	30.00
31.00	03100	681	2,700	258	0	208	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,820	4,914	19,912	0	2,737	50.00
53.00	05300	0	0	1,454	0	594	53.00
54.00	05400	3,112	0	3,027	0	3,289	54.00
57.00	05700	0	0	1,670	0	2,424	57.00
58.00	05800	156	0	497	0	917	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	1,732	1,452	1,462	0	3,632	60.00
62.00	06200	0	0	0	0	0	62.00
65.00	06500	1,121	0	674	0	441	65.00
66.00	06600	582	0	76	582	486	66.00
67.00	06700	333	0	6	0	151	67.00
68.00	06800	126	0	1	0	54	68.00
69.00	06900	238	0	14	0	830	69.00
71.00	07100	0	0	7,062	0	254	71.00
72.00	07200	0	0	4,016	0	77	72.00
73.00	07300	0	0	0	27,756	3,516	73.00
76.97	07697	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	2,931	9,588	6,649	0	5,113	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		18,973	32,795	50,704	27,756	26,747	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	211	0	4	0	0	193.01
194.00	07950	202	0	18	0	2	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		19,386	32,795	50,726	27,756	26,749	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150102

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

Worksheet B
Part II
Date/Time Prepared:
5/28/2014 10:17 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
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				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	198,509	0	198,509	30.00
31.00	03100	25,075	0	25,075	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	190,203	0	190,203	50.00
53.00	05300	2,192	0	2,192	53.00
54.00	05400	694,417	0	694,417	54.00
57.00	05700	90,724	0	90,724	57.00
58.00	05800	52,017	0	52,017	58.00
59.00	05900	0	0	0	59.00
60.00	06000	107,992	0	107,992	60.00
62.00	06200	0	0	0	62.00
65.00	06500	46,675	0	46,675	65.00
66.00	06600	28,590	0	28,590	66.00
67.00	06700	11,367	0	11,367	67.00
68.00	06800	5,828	0	5,828	68.00
69.00	06900	23,257	0	23,257	69.00
71.00	07100	13,603	0	13,603	71.00
72.00	07200	9,217	0	9,217	72.00
73.00	07300	60,766	0	60,766	73.00
76.97	07697	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	179,587	0	179,587	91.00
92.00	09200		0		92.00
SPECIAL PURPOSE COST CENTERS					
118.00		1,740,019	0	1,740,019	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	1,285	0	1,285	190.00
193.00	19300	0	0	0	193.00
193.01	19301	4,318	0	4,318	193.01
194.00	07950	98,296	0	98,296	194.00
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		1,843,918	0	1,843,918	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150102

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

Worksheet B-1
Date/Time Prepared:
5/28/2014 10:17 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	84,693				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		84,693			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	274	274	6,877,813		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	8,812	8,812	897,895	-7,105,910	5.00
7.00 00700	OPERATION OF PLANT	27,232	27,232	316,776	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	345	345	0	0	8.00
9.00 00900	HOUSEKEEPING	329	329	165,492	0	9.00
10.00 01000	DIETARY	848	848	78,256	0	10.00
11.00 01100	CAFETERIA	1,471	1,471	135,678	0	11.00
13.00 01300	NURSING ADMINISTRATION	73	73	378,950	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,348	1,348	78,821	0	14.00
15.00 01500	PHARMACY	533	533	198,286	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,147	1,147	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	8,215	8,215	925,017	0	30.00
31.00 03100	INTENSIVE CARE UNIT	589	589	192,371	0	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	6,509	6,509	521,873	0	50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,200	4,200	908,516	0	54.00
57.00 05700	CT SCAN	369	369	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	344	344	55,032	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	1,936	1,936	421,321	0	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
65.00 06500	RESPIRATORY THERAPY	2,169	2,169	329,271	0	65.00
66.00 06600	PHYSICAL THERAPY	1,542	1,542	137,921	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	222	222	113,027	0	67.00
68.00 06800	SPEECH PATHOLOGY	222	222	53,629	0	68.00
69.00 06900	ELECTROCARDIOLOGY	428	428	81,488	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97 07697	CARDIAC REHAB	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	2,696	2,696	822,942	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	71,853	71,853	6,812,562	-7,105,910	14,007,832 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	214	214	0	0	311 190.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
193.01 19301	WELLNESS CENTER	0	0	44,614	0	71,381 193.01
194.00 07950	OTHER NRCC	12,626	12,626	20,637	0	117,651 194.00
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)	88,917	33,853	2,247,590		7,105,910 202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1.049874	0.399714	0.326788		0.500516 203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			398		815,519 204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000058		0.057442 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150102

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

Worksheet B-1
Date/Time Prepared:
5/28/2014 10:17 am

Cost Center Description		OPERATION OF PLANT (SQURE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700	48,375					7.00
8.00	00800	345	2,028				8.00
9.00	00900	329	0	35,301			9.00
10.00	01000	848	0	848	2,028		10.00
11.00	01100	1,471	0	1,471	0	9,201	11.00
13.00	01300	73	0	73	0	581	13.00
14.00	01400	1,348	0	1,348	0	201	14.00
15.00	01500	533	0	533	0	270	15.00
16.00	01600	1,147	0	1,147	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	8,215	1,802	8,215	1,802	1,863	30.00
31.00	03100	589	226	589	226	323	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	6,509	0	6,509	0	864	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	4,200	0	4,200	0	1,477	54.00
57.00	05700	369	0	369	0	0	57.00
58.00	05800	344	0	344	0	74	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	1,936	0	1,936	0	822	60.00
62.00	06200	0	0	0	0	0	62.00
65.00	06500	2,169	0	2,169	0	532	65.00
66.00	06600	1,542	0	1,542	0	276	66.00
67.00	06700	222	0	222	0	158	67.00
68.00	06800	222	0	222	0	60	68.00
69.00	06900	428	0	428	0	113	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.97	07697	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	2,696	0	2,696	0	1,391	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		35,535	2,028	34,861	2,028	9,005	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	214	0	214	0	0	190.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	100	193.01
194.00	07950	12,626	0	226	0	96	194.00
200.00							200.00
201.00							201.00
202.00		1,837,877	13,857	510,187	266,446	355,943	202.00
203.00		37.992289	6.832840	14.452480	131.383629	38.685252	203.00
204.00		186,131	1,856	21,915	15,641	19,386	204.00
205.00		3.847669	0.915187	0.620804	7.712525	2.106945	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150102

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

Worksheet B-1

Date/Time Prepared:
5/28/2014 10:17 am

Cost Center Description		NURSING ADMINISTRATION (TOTAL NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300	1,938,704				13.00
14.00	01400	0	786,268			14.00
15.00	01500	0	11,844	100		15.00
16.00	01600	0	0	0	68,865,737	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	835,920	49,010	0	5,217,410	30.00
31.00	03100	159,636	3,995	0	536,063	31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	290,484	308,653	0	7,053,967	50.00
53.00	05300	0	22,543	0	1,532,014	53.00
54.00	05400	0	46,924	0	8,476,629	54.00
57.00	05700	0	25,892	0	6,247,839	57.00
58.00	05800	0	7,700	0	2,362,489	58.00
59.00	05900	0	0	0	0	59.00
60.00	06000	85,847	22,659	0	9,360,764	60.00
62.00	06200	0	0	0	0	62.00
65.00	06500	0	10,444	0	1,137,488	65.00
66.00	06600	0	1,184	0	1,253,369	66.00
67.00	06700	0	86	0	388,908	67.00
68.00	06800	0	13	0	140,116	68.00
69.00	06900	0	210	0	2,138,514	69.00
71.00	07100	0	109,458	0	653,878	71.00
72.00	07200	0	62,249	0	197,981	72.00
73.00	07300	0	0	100	9,062,258	73.00
76.97	07697	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	566,817	103,061	0	13,101,358	91.00
92.00	09200					92.00
SPECIAL PURPOSE COST CENTERS						
118.00		1,938,704	785,925	100	68,861,045	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0	0	190.00
193.00	19300	0	0	0	0	193.00
193.01	19301	0	66	0	0	193.01
194.00	07950	0	277	0	4,692	194.00
200.00						200.00
201.00						201.00
202.00		839,138	1,111,655	594,533	581,607	202.00
203.00		0.432835	1.413837	5,945.330000	0.008446	203.00
204.00		32,795	50,726	27,756	26,749	204.00
205.00		0.016916	0.064515	277.560000	0.000388	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150102

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

Worksheet C
Part I
Date/Time Prepared:
5/28/2014 10:17 am

		Title XVIII		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		3,297,375	0	3,297,375	30.00
31.00	03100 INTENSIVE CARE UNIT		566,152	0	566,152	31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		2,380,505	0	2,380,505	50.00
53.00	05300 ANESTHESIOLOGY		48,585	0	48,585	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		4,293,912	0	4,293,912	54.00
57.00	05700 CT SCAN		390,646	0	390,646	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		438,309	0	438,309	58.00
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	06000 LABORATORY		2,260,519	1,078	2,261,597	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	881,713	0	881,713	65.00
66.00	06600 PHYSICAL THERAPY	0	411,803	0	411,803	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	260,364	0	260,364	67.00
68.00	06800 SPEECH PATHOLOGY	0	128,286	0	128,286	68.00
69.00	06900 ELECTROCARDIOLOGY		256,034	0	256,034	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		324,522	0	324,522	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		185,455	0	185,455	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		1,441,534	0	1,441,534	73.00
76.97	07697 CARDIAC REHAB		0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY		2,950,969	191,546	3,142,515	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1,459,372		1,459,372	92.00
200.00	Subtotal (see instructions)	0	21,976,055	192,624	22,168,679	200.00
201.00	Less Observation Beds		1,459,372		1,459,372	201.00
202.00	Total (see instructions)	0	20,516,683	192,624	20,709,307	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/28/2014 10:17 am
		Title XVIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
9.00	10.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,226,352		3,226,352	30.00
31.00	03100	INTENSIVE CARE UNIT	536,063		536,063	31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	931,897	6,202,607	7,134,504	50.00
53.00	05300	ANESTHESIOLOGY	189,467	1,342,547	1,532,014	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	396,746	8,079,883	8,476,629	54.00
57.00	05700	CT SCAN	649,670	5,598,169	6,247,839	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	77,313	2,285,176	2,362,489	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	1,542,263	7,818,501	9,360,764	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	664,885	472,603	1,137,488	65.00
66.00	06600	PHYSICAL THERAPY	77,456	1,175,913	1,253,369	66.00
67.00	06700	OCCUPATIONAL THERAPY	27,937	360,971	388,908	67.00
68.00	06800	SPEECH PATHOLOGY	12,696	127,420	140,116	68.00
69.00	06900	ELECTROCARDIOLOGY	339,677	1,798,837	2,138,514	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	317,655	336,223	653,878	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26,470	171,511	197,981	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,392,248	5,670,010	9,062,258	73.00
76.97	07697	CARDIAC REHAB	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	867,784	12,233,574	13,101,358	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	294,730	1,696,328	1,991,058	92.00
200.00		Subtotal (see instructions)	13,571,309	55,370,273	68,941,582	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	13,571,309	55,370,273	68,941,582	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/28/2014 10:17 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.333661		50.00
53.00	05300 ANESTHESIOLOGY	0.031713		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.506559		54.00
57.00	05700 CT SCAN	0.062525		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.185528		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.241604		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	06500 RESPIRATORY THERAPY	0.775140		65.00
66.00	06600 PHYSICAL THERAPY	0.328557		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.669475		67.00
68.00	06800 SPEECH PATHOLOGY	0.915570		68.00
69.00	06900 ELECTROCARDIOLOGY	0.119725		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.496304		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.936731		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.159070		73.00
76.97	07697 CARDIAC REHAB	0.000000		76.97
	OUTPATIENT SERVICE COST CENTERS			
91.00	09100 EMERGENCY	0.239862		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.732963		92.00
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: 150102

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

Worksheet C
Part I
Date/Time Prepared:
5/28/2014 10:17 am

		Title XIX		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	3,297,375		3,297,375	0	3,297,375
31.00	03100 INTENSIVE CARE UNIT	566,152		566,152	0	566,152
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2,380,505		2,380,505	0	2,380,505
53.00	05300 ANESTHESIOLOGY	48,585		48,585	0	48,585
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,293,912		4,293,912	0	4,293,912
57.00	05700 CT SCAN	390,646		390,646	0	390,646
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	438,309		438,309	0	438,309
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0
60.00	06000 LABORATORY	2,260,519		2,260,519	1,078	2,261,597
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0
65.00	06500 RESPIRATORY THERAPY	881,713	0	881,713	0	881,713
66.00	06600 PHYSICAL THERAPY	411,803	0	411,803	0	411,803
67.00	06700 OCCUPATIONAL THERAPY	260,364	0	260,364	0	260,364
68.00	06800 SPEECH PATHOLOGY	128,286	0	128,286	0	128,286
69.00	06900 ELECTROCARDIOLOGY	256,034		256,034	0	256,034
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	324,522		324,522	0	324,522
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	185,455		185,455	0	185,455
73.00	07300 DRUGS CHARGED TO PATIENTS	1,441,534		1,441,534	0	1,441,534
76.97	07697 CARDIAC REHAB	0		0	0	0
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	2,950,969		2,950,969	191,546	3,142,515
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,459,372		1,459,372		1,459,372
200.00	Subtotal (see instructions)	21,976,055	0	21,976,055	192,624	22,168,679
201.00	Less Observation Beds	1,459,372		1,459,372		1,459,372
202.00	Total (see instructions)	20,516,683	0	20,516,683	192,624	20,709,307

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150102

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

Worksheet C
Part I
Date/Time Prepared:
5/28/2014 10:17 am

		Title XIX			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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,226,352		3,226,352		30.00
31.00	03100	INTENSIVE CARE UNIT	536,063		536,063		31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	931,897	6,202,607	7,134,504	0.333661	50.00
53.00	05300	ANESTHESIOLOGY	189,467	1,342,547	1,532,014	0.031713	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	396,746	8,079,883	8,476,629	0.506559	54.00
57.00	05700	CT SCAN	649,670	5,598,169	6,247,839	0.062525	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	77,313	2,285,176	2,362,489	0.185528	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	1,542,263	7,818,501	9,360,764	0.241489	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	664,885	472,603	1,137,488	0.775140	65.00
66.00	06600	PHYSICAL THERAPY	77,456	1,175,913	1,253,369	0.328557	66.00
67.00	06700	OCCUPATIONAL THERAPY	27,937	360,971	388,908	0.669475	67.00
68.00	06800	SPEECH PATHOLOGY	12,696	127,420	140,116	0.915570	68.00
69.00	06900	ELECTROCARDIOLOGY	339,677	1,798,837	2,138,514	0.119725	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	317,655	336,223	653,878	0.496304	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26,470	171,511	197,981	0.936731	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,392,248	5,670,010	9,062,258	0.159070	73.00
76.97	07697	CARDIAC REHAB	0	0	0	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	867,784	12,233,574	13,101,358	0.225241	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	294,730	1,696,328	1,991,058	0.732963	92.00
200.00		Subtotal (see instructions)	13,571,309	55,370,273	68,941,582		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	13,571,309	55,370,273	68,941,582		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/28/2014 10:17 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital PPS
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.333661		50.00
53.00	05300 ANESTHESIOLOGY	0.031713		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.506559		54.00
57.00	05700 CT SCAN	0.062525		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.185528		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.241604		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	06500 RESPIRATORY THERAPY	0.775140		65.00
66.00	06600 PHYSICAL THERAPY	0.328557		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.669475		67.00
68.00	06800 SPEECH PATHOLOGY	0.915570		68.00
69.00	06900 ELECTROCARDIOLOGY	0.119725		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.496304		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.936731		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.159070		73.00
76.97	07697 CARDIAC REHAB	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0.239862		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.732963		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

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

Provider CCN: 150102

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

Worksheet C Part II Date/Time Prepared: 5/28/2014 10:17 am

Cost Center Description			Title XIX			Hospital		PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
			1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	2,380,505	190,203	2,190,302	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	48,585	2,192	46,393	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,293,912	694,417	3,599,495	0	0	54.00	
57.00	05700	CT SCAN	390,646	90,724	299,922	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	438,309	52,017	386,292	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00	06000	LABORATORY	2,260,519	107,992	2,152,527	0	0	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00	
65.00	06500	RESPIRATORY THERAPY	881,713	46,675	835,038	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	411,803	28,590	383,213	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	260,364	11,367	248,997	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	128,286	5,828	122,458	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	256,034	23,257	232,777	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	324,522	13,603	310,919	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	185,455	9,217	176,238	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1,441,534	60,766	1,380,768	0	0	73.00	
76.97	07697	CARDIAC REHAB	0	0	0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	2,950,969	179,587	2,771,382	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,459,372	87,857	1,371,515	0	0	92.00	
200.00		Subtotal (sum of lines 50 thru 199)	18,112,528	1,604,292	16,508,236	0	0	200.00	
201.00		Less Observation Beds	1,459,372	87,857	1,371,515	0	0	201.00	
202.00		Total (line 200 minus line 201)	16,653,156	1,516,435	15,136,721	0	0	202.00	

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

Provider CCN: 150102

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

Worksheet C
Part II
Date/Time Prepared:
5/28/2014 10:17 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
		6.00	7.00	8.00		
Title XIX Hospital PPS						
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,380,505	7,134,504	0.333661	50.00
53.00	05300	ANESTHESIOLOGY	48,585	1,532,014	0.031713	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,293,912	8,476,629	0.506559	54.00
57.00	05700	CT SCAN	390,646	6,247,839	0.062525	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	438,309	2,362,489	0.185528	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	59.00
60.00	06000	LABORATORY	2,260,519	9,360,764	0.241489	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	881,713	1,137,488	0.775140	65.00
66.00	06600	PHYSICAL THERAPY	411,803	1,253,369	0.328557	66.00
67.00	06700	OCCUPATIONAL THERAPY	260,364	388,908	0.669475	67.00
68.00	06800	SPEECH PATHOLOGY	128,286	140,116	0.915570	68.00
69.00	06900	ELECTROCARDIOLOGY	256,034	2,138,514	0.119725	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	324,522	653,878	0.496304	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	185,455	197,981	0.936731	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,441,534	9,062,258	0.159070	73.00
76.97	07697	CARDIAC REHAB	0	0	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,950,969	13,101,358	0.225241	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,459,372	1,991,058	0.732963	92.00
200.00		Subtotal (sum of lines 50 thru 199)	18,112,528	65,179,167		200.00
201.00		Less Observation Beds	1,459,372	0		201.00
202.00		Total (line 200 minus line 201)	16,653,156	65,179,167		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150102		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part I Date/Time Prepared: 5/28/2014 10:17 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	198,509	0	198,509	3,109	63.85	30.00
31.00	INTENSIVE CARE UNIT	25,075		25,075	226	110.95	31.00
200.00	Total (Lines 30-199)	223,584		223,584	3,335		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	1,263	80,643				
31.00	INTENSIVE CARE UNIT	87	9,653				
200.00	Total (Lines 30-199)	1,350	90,296				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/28/2014 10:17 am
		Title XVIII	Hospital	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	190,203	7,134,504	0.026660	532,535	14,197	50.00
53.00	05300 ANESTHESIOLOGY	2,192	1,532,014	0.001431	109,156	156	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	694,417	8,476,629	0.081921	265,289	21,733	54.00
57.00	05700 CT SCAN	90,724	6,247,839	0.014521	420,565	6,107	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	52,017	2,362,489	0.022018	53,617	1,181	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	107,992	9,360,764	0.011537	1,042,063	12,022	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	46,675	1,137,488	0.041033	459,722	18,864	65.00
66.00	06600 PHYSICAL THERAPY	28,590	1,253,369	0.022811	64,038	1,461	66.00
67.00	06700 OCCUPATIONAL THERAPY	11,367	388,908	0.029228	21,280	622	67.00
68.00	06800 SPEECH PATHOLOGY	5,828	140,116	0.041594	9,413	392	68.00
69.00	06900 ELECTROCARDIOLOGY	23,257	2,138,514	0.010875	241,554	2,627	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	13,603	653,878	0.020804	225,934	4,700	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	9,217	197,981	0.046555	17,782	828	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	60,766	9,062,258	0.006705	2,178,276	14,605	73.00
76.97	07697 CARDIAC REHAB	0	0	0.000000	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	179,587	13,101,358	0.013708	560,217	7,679	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	87,857	1,991,058	0.044126	209,402	9,240	92.00
200.00	Total (lines 50-199)	1,604,292	65,179,167		6,410,843	116,414	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150102		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part III Date/Time Prepared: 5/28/2014 10:17 am	
Cost Center Description			Title XVIII		Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	
200.00		Total (lines 30-199)	0	0	0	0	0	
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,109	0.00	1,263	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	226	0.00	87	0	31.00	
200.00		Total (lines 30-199)	3,335		1,350	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150102

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

Worksheet D
Part IV
Date/Time Prepared:
5/28/2014 10:17 am

Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHAB	0	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/28/2014 10:17 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	7,134,504	0.000000	0.000000	532,535	50.00
53.00	05300 ANESTHESIOLOGY	0	1,532,014	0.000000	0.000000	109,156	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	8,476,629	0.000000	0.000000	265,289	54.00
57.00	05700 CT SCAN	0	6,247,839	0.000000	0.000000	420,565	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	2,362,489	0.000000	0.000000	53,617	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	9,360,764	0.000000	0.000000	1,042,063	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0.000000	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	1,137,488	0.000000	0.000000	459,722	65.00
66.00	06600 PHYSICAL THERAPY	0	1,253,369	0.000000	0.000000	64,038	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	388,908	0.000000	0.000000	21,280	67.00
68.00	06800 SPEECH PATHOLOGY	0	140,116	0.000000	0.000000	9,413	68.00
69.00	06900 ELECTROCARDIOLOGY	0	2,138,514	0.000000	0.000000	241,554	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	653,878	0.000000	0.000000	225,934	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	197,981	0.000000	0.000000	17,782	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	9,062,258	0.000000	0.000000	2,178,276	73.00
76.97	07697 CARDIAC REHAB	0	0	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0	13,101,358	0.000000	0.000000	560,217	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,991,058	0.000000	0.000000	209,402	92.00
200.00	Total (lines 50-199)	0	65,179,167			6,410,843	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/28/2014 10:17 am
	Title XVIII	Hospital	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	2,213,069	0	50.00
53.00	05300 ANESTHESIOLOGY	0	481,284	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	2,290,302	0	54.00
57.00	05700 CT SCAN	0	1,777,988	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	697,006	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	175,728	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	162,003	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,114	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	746,915	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	137,490	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	83,634	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,938,480	0	73.00
76.97	07697 CARDIAC REHAB	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0	1,955,203	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	578,220	0	92.00
200.00	Total (lines 50-199)	0	13,238,436	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/28/2014 10:17 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	0.333661	2,213,069	0	0	738,415	50.00
53.00	05300	ANESTHESIOLOGY	0.031713	481,284	0	0	15,263	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.506559	2,290,302	0	0	1,160,173	54.00
57.00	05700	CT SCAN	0.062525	1,777,988	0	0	111,169	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.185528	697,006	0	0	129,314	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.241489	175,728	0	0	42,436	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.775140	162,003	0	0	125,575	65.00
66.00	06600	PHYSICAL THERAPY	0.328557	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.669475	1,114	0	0	746	67.00
68.00	06800	SPEECH PATHOLOGY	0.915570	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.119725	746,915	0	0	89,424	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.496304	137,490	0	0	68,237	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.936731	83,634	0	0	78,343	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.159070	1,938,480	0	37,057	308,354	73.00
76.97	07697	CARDIAC REHAB	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.225241	1,955,203	0	0	440,392	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.732963	578,220	0	0	423,814	92.00
200.00		Subtotal (see instructions)		13,238,436	0	37,057	3,731,655	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		13,238,436	0	37,057	3,731,655	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/28/2014 10:17 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
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
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	5,895		73.00
76.97 07697 CARDIAC REHAB	0	0		76.97
OUTPATIENT SERVICE COST CENTERS				
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00 Subtotal (see instructions)	0	5,895		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	5,895		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150102		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part I Date/Time Prepared: 5/28/2014 10:17 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	198,509	0	198,509	3,109	63.85	30.00
31.00	INTENSIVE CARE UNIT	25,075		25,075	226	110.95	31.00
200.00	Total (Lines 30-199)	223,584		223,584	3,335		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	153	9,769				
31.00	INTENSIVE CARE UNIT	20	2,219				
200.00	Total (Lines 30-199)	173	11,988				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/28/2014 10:17 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)	Hospital		Capital Costs (column 3 x column 4)	
					Inpatient Program Charges	PPS		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	190,203	7,134,504	0.026660	43,137	1,150	50.00
53.00	05300	ANESTHESIOLOGY	2,192	1,532,014	0.001431	8,089	12	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	694,417	8,476,629	0.081921	16,349	1,339	54.00
57.00	05700	CT SCAN	90,724	6,247,839	0.014521	42,752	621	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	52,017	2,362,489	0.022018	9,420	207	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	107,992	9,360,764	0.011537	139,667	1,611	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	46,675	1,137,488	0.041033	48,681	1,998	65.00
66.00	06600	PHYSICAL THERAPY	28,590	1,253,369	0.022811	2,957	67	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,367	388,908	0.029228	1,404	41	67.00
68.00	06800	SPEECH PATHOLOGY	5,828	140,116	0.041594	2,390	99	68.00
69.00	06900	ELECTROCARDIOLOGY	23,257	2,138,514	0.010875	18,693	203	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,603	653,878	0.020804	19,113	398	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,217	197,981	0.046555	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60,766	9,062,258	0.006705	283,190	1,899	73.00
76.97	07697	CARDIAC REHAB	0	0	0.000000	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	179,587	13,101,358	0.013708	82,990	1,138	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	87,857	1,991,058	0.044126	4,747	209	92.00
200.00		Total (lines 50-199)	1,604,292	65,179,167		723,579	10,992	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150102		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part III Date/Time Prepared: 5/28/2014 10:17 am	
Cost Center Description			Title XIX		Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,109	0.00	153	0		30.00
31.00	03100	INTENSIVE CARE UNIT	226	0.00	20	0		31.00
200.00		Total (lines 30-199)	3,335		173	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150102

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

Worksheet D
Part IV
Date/Time Prepared:
5/28/2014 10:17 am

Cost Center Description		Title XIX				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
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	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
76.97	07697	CARDIAC REHAB	0	0	0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	0	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
200.00		Total (lines 50-199)	0	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/28/2014 10:17 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		
				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
				6.00	7.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	7,134,504	0.000000	0.000000	43,137	50.00
53.00 05300 ANESTHESIOLOGY	0	1,532,014	0.000000	0.000000	8,089	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	8,476,629	0.000000	0.000000	16,349	54.00
57.00 05700 CT SCAN	0	6,247,839	0.000000	0.000000	42,752	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	2,362,489	0.000000	0.000000	9,420	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00 06000 LABORATORY	0	9,360,764	0.000000	0.000000	139,667	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0.000000	0	62.00
65.00 06500 RESPIRATORY THERAPY	0	1,137,488	0.000000	0.000000	48,681	65.00
66.00 06600 PHYSICAL THERAPY	0	1,253,369	0.000000	0.000000	2,957	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	388,908	0.000000	0.000000	1,404	67.00
68.00 06800 SPEECH PATHOLOGY	0	140,116	0.000000	0.000000	2,390	68.00
69.00 06900 ELECTROCARDIOLOGY	0	2,138,514	0.000000	0.000000	18,693	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	653,878	0.000000	0.000000	19,113	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	197,981	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	9,062,258	0.000000	0.000000	283,190	73.00
76.97 07697 CARDIAC REHAB	0	0	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0	13,101,358	0.000000	0.000000	82,990	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,991,058	0.000000	0.000000	4,747	92.00
200.00 Total (lines 50-199)	0	65,179,167			723,579	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/28/2014 10:17 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
Title XIX Hospital PPS						
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.97	07697 CARDIAC REHAB	0	0	0		76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/28/2014 10:17 am
	Title XIX	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	0.333661	0	1,180,242	0	0
53.00 05300 ANESTHESIOLOGY	0.031713	0	243,487	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.506559	0	1,121,345	0	0
57.00 05700 CT SCAN	0.062525	0	883,141	0	0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.185528	0	551,568	0	0
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00 06000 LABORATORY	0.241489	0	1,399,698	0	0
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0
65.00 06500 RESPIRATORY THERAPY	0.775140	0	98,434	0	0
66.00 06600 PHYSICAL THERAPY	0.328557	0	184,119	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.669475	0	129,189	0	0
68.00 06800 SPEECH PATHOLOGY	0.915570	0	62,327	0	0
69.00 06900 ELECTROCARDIOLOGY	0.119725	0	224,347	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.496304	0	75,190	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.936731	0	9,624	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.159070	0	958,283	0	0
76.97 07697 CARDIAC REHAB	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
91.00 09100 EMERGENCY	0.225241	0	2,251,641	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.732963	0	641,095	0	0
200.00	Subtotal (see instructions)	0	10,013,730	0	0
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0	0
202.00	Net Charges (line 200 +/- line 201)	0	10,013,730	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/28/2014 10:17 am
	Title XIX	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	393,801	0		50.00
53.00 05300 ANESTHESIOLOGY	7,722	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	568,027	0		54.00
57.00 05700 CT SCAN	55,218	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	102,331	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	338,012	0		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00 06500 RESPIRATORY THERAPY	76,300	0		65.00
66.00 06600 PHYSICAL THERAPY	60,494	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	86,489	0		67.00
68.00 06800 SPEECH PATHOLOGY	57,065	0		68.00
69.00 06900 ELECTROCARDIOLOGY	26,860	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	37,317	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	9,015	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	152,434	0		73.00
76.97 07697 CARDIAC REHAB	0	0		76.97
OUTPATIENT SERVICE COST CENTERS				
91.00 09100 EMERGENCY	507,162	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	469,899	0		92.00
200.00	Subtotal (see instructions)	2,948,146	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	2,948,146	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/28/2014 10:17 am
Cost Center Description		PPS		
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,165	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,109	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)		1,733	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		56	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)		1,263	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)		50	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)		3,297,375	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,297,375	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)		3,297,375	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)		1,060.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,339,525	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,339,525	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/28/2014 10:17 am
Cost Center Description			Title XVIII		PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	566,152	226	2,505.10	87	217,944
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
Cost Center Description					
					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				1,795,862
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				3,353,331
PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				90,296
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				116,414
52.00	Total Program excludable cost (sum of lines 50 and 51)				206,710
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				3,146,621
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				0
55.00	Target amount per discharge				0.00
56.00	Target amount (line 54 x line 55)				0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0
58.00	Bonus payment (see instructions)				0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0
62.00	Relief payment (see instructions)				0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)				70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				71.00
72.00	Program routine service cost (line 9 x line 71)				72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				76.00
77.00	Program capital-related costs (line 9 x line 76)				77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				80.00
81.00	Inpatient routine service cost per diem limitation				81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				82.00
83.00	Reasonable inpatient routine service costs (see instructions)				83.00
84.00	Program inpatient ancillary services (see instructions)				84.00
85.00	Utilization review - physician compensation (see instructions)				85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)				1,376
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,060.59
89.00	Observation bed cost (line 87 x line 88) (see instructions)				1,459,372

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150102		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/28/2014 10:17 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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	198,509	3,297,375	0.060202	1,459,372	87,857	90.00
91.00	Nursing School cost	0	3,297,375	0.000000	1,459,372	0	91.00
92.00	Allied health cost	0	3,297,375	0.000000	1,459,372	0	92.00
93.00	All other Medical Education	0	3,297,375	0.000000	1,459,372	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/28/2014 10:17 am
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,165	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,109	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)		1,733	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		56	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)		153	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)		3,297,375	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,297,375	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)		3,297,375	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)		1,060.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		162,270	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)		162,270	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/28/2014 10:17 am		
Cost Center Description			Title XIX		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	566,152	226	2,505.10	20	50,102	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)					183,088	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					395,460	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)					11,988	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					10,992	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					22,980	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					372,480	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)					1,376	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,060.59	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,459,372	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150102		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/28/2014 10:17 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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	198,509	3,297,375	0.060202	1,459,372	87,857	90.00
91.00	Nursing School cost	0	3,297,375	0.000000	1,459,372	0	91.00
92.00	Allied health cost	0	3,297,375	0.000000	1,459,372	0	92.00
93.00	All other Medical Education	0	3,297,375	0.000000	1,459,372	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/28/2014 10:17 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		1,560,915	30.00
31.00	03100	INTENSIVE CARE UNIT		220,631	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.333661	532,535	177,686 50.00
53.00	05300	ANESTHESIOLOGY	0.031713	109,156	3,462 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.506559	265,289	134,385 54.00
57.00	05700	CT SCAN	0.062525	420,565	26,296 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.185528	53,617	9,947 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000	LABORATORY	0.241604	1,042,063	251,767 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0 62.00
65.00	06500	RESPIRATORY THERAPY	0.775140	459,722	356,349 65.00
66.00	06600	PHYSICAL THERAPY	0.328557	64,038	21,040 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.669475	21,280	14,246 67.00
68.00	06800	SPEECH PATHOLOGY	0.915570	9,413	8,618 68.00
69.00	06900	ELECTROCARDIOLOGY	0.119725	241,554	28,920 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.496304	225,934	112,132 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.936731	17,782	16,657 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.159070	2,178,276	346,498 73.00
76.97	07697	CARDIAC REHAB	0.000000	0	0 76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.239862	560,217	134,375 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.732963	209,402	153,484 92.00
200.00		Total (sum of lines 50-94 and 96-98)		6,410,843	1,795,862 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		6,410,843	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3	
		Component CCN: 15U102		Date/Time Prepared: 5/28/2014 10:17 am	
		Title XVIII	Swing Beds - SNF	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
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.333661	0	50.00
53.00	05300	ANESTHESIOLOGY	0.031713	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.506559	0	54.00
57.00	05700	CT SCAN	0.062525	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.185528	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.241489	1,083	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.775140	3,130	65.00
66.00	06600	PHYSICAL THERAPY	0.328557	2,282	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.669475	3,011	67.00
68.00	06800	SPEECH PATHOLOGY	0.915570	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.119725	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.496304	1,385	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.936731	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.159070	11,592	73.00
76.97	07697	CARDIAC REHAB	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.225241	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.732963	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		22,483	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)		22,483	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/28/2014 10:17 am
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Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000				
	ADULTS & PEDIATRICS		220,893		30.00
31.00	03100		0		31.00
	INTENSIVE CARE UNIT				
ANCILLARY SERVICE COST CENTERS					
50.00	05000	0.333661	43,137	14,393	50.00
	OPERATING ROOM				
53.00	05300	0.031713	8,089	257	53.00
	ANESTHESIOLOGY				
54.00	05400	0.506559	16,349	8,282	54.00
	RADIOLOGY-DIAGNOSTIC				
57.00	05700	0.062525	42,752	2,673	57.00
	CT SCAN				
58.00	05800	0.185528	9,420	1,748	58.00
	MAGNETIC RESONANCE IMAGING (MRI)				
59.00	05900	0.000000	0	0	59.00
	CARDIAC CATHETERIZATION				
60.00	06000	0.241604	139,667	33,744	60.00
	LABORATORY				
62.00	06200	0.000000	0	0	62.00
	WHOLE BLOOD & PACKED RED BLOOD CELLS				
65.00	06500	0.775140	48,681	37,735	65.00
	RESPIRATORY THERAPY				
66.00	06600	0.328557	2,957	972	66.00
	PHYSICAL THERAPY				
67.00	06700	0.669475	1,404	940	67.00
	OCCUPATIONAL THERAPY				
68.00	06800	0.915570	2,390	2,188	68.00
	SPEECH PATHOLOGY				
69.00	06900	0.119725	18,693	2,238	69.00
	ELECTROCARDIOLOGY				
71.00	07100	0.496304	19,113	9,486	71.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS				
72.00	07200	0.936731	0	0	72.00
	IMPL. DEV. CHARGED TO PATIENTS				
73.00	07300	0.159070	283,190	45,047	73.00
	DRUGS CHARGED TO PATIENTS				
76.97	07697	0.000000	0	0	76.97
	CARDIAC REHAB				
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	0.239862	82,990	19,906	91.00
	EMERGENCY				
92.00	09200	0.732963	4,747	3,479	92.00
	OBSERVATION BEDS (NON-DISTINCT PART)				
200.00			723,579	183,088	200.00
	Total (sum of lines 50-94 and 96-98)				
201.00			0	0	201.00
	Less PBP Clinic Laboratory Services-Program only charges (line 61)				
202.00			723,579		202.00
	Net Charges (line 200 minus line 201)				

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/28/2014 10:17 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)		1,422,948	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		385,209	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)		61,179	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)		47.32	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)		7.32	30.00
31.00	Percentage of Medicaid patient days (see instructions)		9.63	31.00
32.00	Sum of lines 30 and 31		16.95	32.00
33.00	Allowable disproportionate share percentage (see instructions)		3.77	33.00
34.00	Disproportionate share adjustment (see instructions)		57,276	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/28/2014 10:17 am	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1	On/After October 1	
			1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)			9,046,380,143	35.00
35.01	Factor 3 (see instructions)			0.000012564	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			114,477	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			28,855	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		28,855		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)		1,955,467		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		1,721,561		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		1,955,467		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		143,460		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)		2,098,927		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		2,098,927		61.00
62.00	Deductibles billed to program beneficiaries		304,120		62.00
63.00	Coinurance billed to program beneficiaries		4,440		63.00
64.00	Allowable bad debts (see instructions)		25,293		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		16,440		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		25,293		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		1,806,807		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0		68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.92	Bundled Model 1 discount amount		0		70.92
70.93	HVBP incentive payment (see instructions)		-10,439		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		-18,428		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)	2013	319,798		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)	2014	91,833		70.97
70.98	Low Volume Payment-3		0		70.98

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/28/2014 10:17 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)		2,189,571		71.00
71.01	Sequestration adjustment (see instructions)		33,063		71.01
72.00	Interim payments		2,122,837		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		33,671		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		117,292		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

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150102

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/28/2014 10:17 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	1,422,948	0	1,422,948	0	1,422,948	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013	1.02	385,209	0	0	385,209	385,209	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	61,179	0	61,179	0	61,179	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	0.0377	0.0377	0.0377	0.0377		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	57,276	0	53,645	3,631	57,276	11.00
11.01	Uncompensated care payments	36.00	28,855	0	0	28,855	28,855	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	1,955,467	0	1,537,772	417,695	1,955,467	13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	48.00	1,721,561	0	1,369,450	352,111	1,721,561	14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49.00	1,955,467	0	1,537,772	417,695	1,955,467	15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50.00	143,460	0	112,798	30,662	143,460	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	1,650,570	448,357	2,098,927	19.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150102

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/28/2014 10:17 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	143,234	0	112,572	30,662	143,234	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	226	0	226	0	226	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	143,460	0	112,798	30,662	143,460	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				0.193750	0.204821		27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.96			319,798		319,798	28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.97				91,833	91,833	29.00
100.00	Transfer low volume adjustments to W/S E Part A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/28/2014 10:17 am
		Title XVII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,895	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		3,731,655	2.00
3.00	PPS payments		2,155,343	3.00
4.00	Outlier payment (see instructions)		47,426	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.872	5.00
6.00	Line 2 times line 5		3,254,003	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		67.69	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		5,895	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		37,057	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)		37,057	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)		37,057	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		31,162	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		5,895	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)		2,202,769	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		554,768	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)		1,653,896	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)		1,653,896	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,653,896	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)		83,182	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		54,068	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		83,182	36.00
37.00	Subtotal (see instructions)		1,707,964	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,707,964	40.00
40.01	Sequestration adjustment (see instructions)		25,790	40.01
41.00	Interim payments		1,659,997	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		22,177	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		396	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150102

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

Worksheet E-1
Part I
Date/Time Prepared:
5/28/2014 10:17 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		2,122,837		1,622,675	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0	01/02/2013	37,322	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		37,322	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)		2,122,837		1,659,997	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		33,671		22,177	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		2,156,508		1,682,174	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: 150102

Period:

Worksheet E-1

Component CCN: 15U102

From 01/01/2013
To 12/31/2013

Part I
Date/Time Prepared:
5/28/2014 10:17 am

Title XVIII

Swing Beds - SNF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		11,918		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		11,918		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		52		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		11,970		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: 150102

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

Worksheet E-1
Part II
Date/Time Prepared:
5/28/2014 10:17 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			546 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			1,350 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			89 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			1,959 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			68,941,582 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			2,845,728 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			1,149,300 8.00
9.00	Sequestration adjustment amount (see instructions)			22,986 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			1,126,314 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			1,053,549 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)			72,765 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 150102

Period:

Worksheet E-2

Component CCN: 15U102

From 01/01/2013

Date/Time Prepared:

To 12/31/2013

5/28/2014 10:17 am

Title XVIII

Swing Beds - SNF

PPS

		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	16,594	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 6 and 7, line 202 for Part B) (For CAH, see instructions)			3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	50	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	16,594	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	16,594	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	16,594	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	4,440	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	12,154	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	12,154	0	19.00
19.01	Sequestration adjustment (see instructions)	184	0	19.01
20.00	Interim payments	11,918	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21	52	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

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

Provider CCN: 150102

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

Worksheet G

Date/Time Prepared:
5/28/2014 10:17 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	2,298,395	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	8,222,095	0	0	0	4.00
5.00	Other receivable	1,714,177	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-6,349,209	0	0	0	6.00
7.00	Inventory	434,939	0	0	0	7.00
8.00	Prepaid expenses	123,912	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,444,309	0	0	0	11.00
FIXED ASSETS						
12.00	Land	142,789	0	0	0	12.00
13.00	Land improvements	4,448	0	0	0	13.00
14.00	Accumulated depreciation	-1,430	0	0	0	14.00
15.00	Buildings	1,509,571	0	0	0	15.00
16.00	Accumulated depreciation	-2,069,553	0	0	0	16.00
17.00	Leasehold improvements	5,017,831	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	8,541,731	0	0	0	23.00
24.00	Accumulated depreciation	-5,198,251	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)	7,947,136	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	14,391,445	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	535,943	0	0	0	37.00
38.00	Salaries, wages, and fees payable	576,034	0	0	0	38.00
39.00	Payroll taxes payable	67,146	0	0	0	39.00
40.00	Notes and loans payable (short term)	122,160	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	817,830	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,119,113	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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,119,113	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	12,272,332				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	12,272,332	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	14,391,445	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150102

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

Worksheet G-1

Date/Time Prepared:
5/28/2014 10:17 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		13,070,628		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		5,798,261			2.00
3.00	Total (sum of line 1 and line 2)		18,868,889		0	3.00
4.00	DECREASE IN LIABILITIES	394,915		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		394,915		0	10.00
11.00	Subtotal (line 3 plus line 10)		19,263,804		0	11.00
12.00	DECREASE IN ASSETS	1,193,211		0		12.00
13.00	INTERCOMPANY CONTRIBUTIONS	5,798,261		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		6,991,472		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		12,272,332		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	DECREASE IN LIABILITIES		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	DECREASE IN ASSETS		0			12.00
13.00	INTERCOMPANY CONTRIBUTIONS		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: 150102

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/28/2014 10:17 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,191,352		3,191,352	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	35,000		35,000	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)	3,226,352		3,226,352	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	536,063		536,063	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)	536,063		536,063	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,762,415		3,762,415	17.00
18.00	Ancillary services	9,807,894	41,441,371	51,249,265	18.00
19.00	Outpatient services	0	13,929,902	13,929,902	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER NON-REIMBURSABLE	0	4,692	4,692	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	13,570,309	55,375,965	68,946,274	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		18,876,897		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)		18,876,897		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150102

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

Worksheet G-3

Date/Time Prepared:
5/28/2014 10:17 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	68,946,274	1.00
2.00	Less contractual allowances and discounts on patients' accounts	45,798,025	2.00
3.00	Net patient revenues (line 1 minus line 2)	23,148,249	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	18,876,897	4.00
5.00	Net income from service to patients (line 3 minus line 4)	4,271,352	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	MISCELLANEOUS INCOME	1,526,909	24.00
25.00	Total other income (sum of lines 6-24)	1,526,909	25.00
26.00	Total (line 5 plus line 25)	5,798,261	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,798,261	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150102	Period: From 01/01/2013 To 12/31/2013	Worksheet L Parts I-III Date/Time Prepared: 5/28/2014 10:17 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		143,234	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		226	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)		5.40	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)		143,460	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