

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: 150001	Period: From 01/01/2013 To 12/31/2013	Worksheet S Parts I-III Date/Time Prepared: 5/28/2014 11:01 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: 11:01 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 JOHNSON MEMORIAL HOSPITAL (150001) for the cost reporting period beginning 01/01/2013 and ending 12/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-134,548	-32,419	-35,539	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	37,742	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
200.00 Total	0	-96,806	-32,419	-35,539	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: 150001		Period: From 01/01/2013 To 12/31/2013		Worksheet S-2 Part I Date/Time Prepared: 5/27/2014 6:07 pm				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1125 WEST JEFFERSON STREET			PO Box:						1.00
2.00	City: FRANKLIN			State: IN		Zip Code: 46131-		County: JOHNSON		2.00
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	JOHNSON MEMORIAL HOSPITAL	150001	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	TODD AIKENS REHAB CENTER	15T001	99915	5	01/01/2005	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	JOHNSON MEMORIAL HOME HEALTH	157510	99915		07/01/1997	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:		To:		
						1.00		2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2013		12/31/2013		20.00
21.00	Type of Control (see instructions)							9		21.00
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y		N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N		N		22.01
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2		N		23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	461	0	0	0	678	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.	258	0	0	0	0				25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150001	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/27/2014 6:07 pm		
		Urban/Rural S	Date of Geogr			
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0			35.00	
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	N		39.00	
		V	XVII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	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/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		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150001		Period: From 01/01/2013 To 12/31/2013		Worksheet S-2 Part I Date/Time Prepared: 5/27/2014 6:07 pm	
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20	
					1.00		
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
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	
<u>Teaching Hospitals that Claim Residents in Non-Provider Settings</u>							
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	
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		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: 150001	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/27/2014 6:07 pm																
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))																
		1.00	2.00	3.00																
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010																				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00															
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))														
		1.00	2.00	3.00	4.00	5.00														
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000														
<table border="1"> <thead> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> <th>3.00</th> <th>4.00</th> <th>5.00</th> </tr> </thead> <tbody> <tr> <td colspan="2"></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>									1.00	2.00	3.00	4.00	5.00							
		1.00	2.00	3.00	4.00	5.00														
Inpatient Psychiatric Facility PPS																				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N															
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				N	0														
Inpatient Rehabilitation Facility PPS																				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				Y															
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				N	0														
<table border="1"> <thead> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> <th>3.00</th> <th>4.00</th> <th>5.00</th> </tr> </thead> <tbody> <tr> <td colspan="2"></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>									1.00	2.00	3.00	4.00	5.00							
		1.00	2.00	3.00	4.00	5.00														
Long Term Care Hospital PPS																				
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N															
TEFRA Providers																				
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N															
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.																			
<table border="1"> <thead> <tr> <th colspan="2"></th> <th>V</th> <th>XIX</th> </tr> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> </tr> </thead> <tbody> <tr> <td colspan="2"></td> <td></td> <td></td> </tr> </tbody> </table>									V	XIX			1.00	2.00						
		V	XIX																	
		1.00	2.00																	
Title V and XIX Services																				
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.				N	Y														
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.				N	N														
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N														
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.				N	N														
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.				N	N														
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00														

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		V	XIX			
		1.00	2.00			
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	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.	Y			117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00	
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	379,065	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	
DO NOT USE THIS LINE						
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150001	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/27/2014 6:07 pm			
		1.00	2.00				
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00	
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?	Y				144.00	
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N				145.00	
				1.00			
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N				147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N				149.00	
		Part A 1.00	Part B 2.00	Title V 3.00	Title XIX 4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
				1.00			
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N				165.00	
		Name 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00 166.00
				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 1.00		Ending 2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2013		12/31/2013		170.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150001	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/27/2014 6:07 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	04/25/2014	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N		Legal Oper.	
		1.00		2.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/03/2014	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 150001

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

Worksheet S-2
Part II
Date/Time Prepared:
5/27/2014 6:07 pm

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
					Y/N
					Date
					1.00
					2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
					1.00
					2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BOB		BRANDENBURG	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.383.4000		B BRANDENBURG@BKD.COM	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	04/03/2014	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PARTNER	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: 150001

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

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2014 6:07 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	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	80	29,200	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)		80	29,200	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	6	2,190	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		86	31,390	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	15	5,475		0	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	101.00				0	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)		101				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: 150001

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

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2014 6:07 pm

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)	3,326	370	6,671			1.00
2.00 HMO and other (see instructions)	1,047	678				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	7	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	3,326	370	6,671			7.00
8.00 INTENSIVE CARE UNIT	339	27	1,028			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		39	664			13.00
14.00 Total (see instructions)	3,665	436	8,363	0.00	577.96	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	1,273	258	1,944	0.00	13.39	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	4,032	120	5,135	0.00	11.41	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	602.76	27.00
28.00 Observation Bed Days		10	1,249			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	25	136			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: 150001

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

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2014 6:07 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	861	86	2,242	1.00
2.00 HMO and other (see instructions)			228			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	861	86	2,242	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	116	14	168	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	0.00					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: 150001

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

Worksheet S-3
Part II
Date/Time Prepared:
5/27/2014 6:07 pm

	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 II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	36,481,628	0	36,481,628	1,253,722.00	29.10
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		11,110,183	-170,213	10,939,970	242,252.00	45.16
OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		917,045	0	917,045	11,738.00	78.13
12.00	Contract management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		130,017	0	130,017	1,770.00	73.46
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		6,547,604	0	6,547,604		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		1,568,183	0	1,568,183		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FOHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	3,126,992	170,213	3,297,205	159,714.00	20.64
27.00	Administrative & General	5.00	2,093,698	0	2,093,698	66,133.00	31.66
28.00	Administrative & General under contract (see inst.)		257,133	0	257,133	1,710.00	150.37
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	685,847	0	685,847	32,265.00	21.26
31.00	Laundry & Linen Service	8.00	129,402	0	129,402	9,877.00	13.10
32.00	Housekeeping	9.00	703,800	0	703,800	59,065.00	11.92
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	867,669	-471,393	396,276	25,428.00	15.58
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	471,393	471,393	30,248.00	15.58
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	1,107,478	0	1,107,478	20,059.00	55.21
39.00	Central Services and Supply	14.00	100,161	0	100,161	5,667.00	17.67
40.00	Pharmacy	15.00	494,588	0	494,588	13,593.00	36.39
41.00	Medical Records & Medical Records Library	16.00	581,884	0	581,884	31,887.00	18.25

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150001

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

Worksheet S-3
Part II
Date/Time Prepared:
5/27/2014 6:07 pm

		Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es 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: 150001

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

Worksheet S-3
Part III
Date/Time Prepared:
5/27/2014 6:07 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	36,738,761	0	36,738,761	1,255,432.00	29.26	1.00
2.00	Excluded area salaries (see instructions)	11,110,183	-170,213	10,939,970	242,252.00	45.16	2.00
3.00	Subtotal salaries (line 1 minus line 2)	25,628,578	170,213	25,798,791	1,013,180.00	25.46	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,047,062	0	1,047,062	13,508.00	77.51	4.00
5.00	Subtotal wage-related costs (see inst.)	6,547,604	0	6,547,604	0.00	25.38	5.00
6.00	Total (sum of lines 3 thru 5)	33,223,244	170,213	33,393,457	1,026,688.00	32.53	6.00
7.00	Total overhead cost (see instructions)	10,148,652	170,213	10,318,865	455,646.00	22.65	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150001	Period: From 01/01/2013 To 12/31/2013	Worksheet S-3 Part IV Date/Time Prepared: 5/27/2014 6:07 pm
			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)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees		852,096	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		282,853	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		2,992,012	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		33,014	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)		73,026	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		197,252	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		1,956,302	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		26,785	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		35,490	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		6,448,830	24.00
Part B - Other than Core Related Cost				
25.00	EXCLUDED BENEFITS		1,666,957	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150001

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

Worksheet S-3
Part V
Date/Time Prepared:
5/27/2014 6:07 pm

Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	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

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 150001 Component CCN: 157510		Period: From 01/01/2013 To 12/31/2013		Worksheet S-4 Date/Time Prepared: 5/27/2014 6:07 pm	
				Home Health Agency I		PPS	
				1.00			
0.00	County			JOHNSON		0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	1,744	0	0	1,744	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	189.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		2.33	0.00	2.33	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			1.03	0.00	1.03	5.00
6.00	Direct Nursing Service			4.35	0.00	4.35	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			1.70	0.00	1.70	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			1.07	0.00	1.07	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.03	0.00	0.03	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.90	0.00	0.90	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			18020			20.00
20.01				26900			20.01
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	1,619	0	52	60	1,731	21.00
22.00	Skilled Nursing Visit Charges	352,537	0	9,953	13,069	375,559	22.00
23.00	Physical Therapy Visits	1,020	0	13	47	1,080	23.00
24.00	Physical Therapy Visit Charges	253,506	0	2,752	11,501	267,759	24.00
25.00	Occupational Therapy Visits	753	0	6	26	785	25.00
26.00	Occupational Therapy Visit Charges	188,527	0	1,502	6,519	196,548	26.00
27.00	Speech Pathology Visits	17	0	0	5	22	27.00
28.00	Speech Pathology Visit Charges	4,261	0	0	1,250	5,511	28.00
29.00	Medical Social Service Visits	3	0	0	0	3	29.00
30.00	Medical Social Service Visit Charges	848	0	0	0	848	30.00
31.00	Home Health Aide Visits	400	0	0	11	411	31.00
32.00	Home Health Aide Visit Charges	40,483	0	0	1,133	41,616	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,812	0	71	149	4,032	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	840,162	0	14,207	33,472	887,841	35.00
36.00	Total Number of Episodes (standard/non outlier)	210		21	11	242	36.00
37.00	Total Number of Outlier Episodes		0		1	1	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150001	Period: From 01/01/2013 To 12/31/2013	Worksheet S-10 Date/Time Prepared: 5/27/2014 6:07 pm
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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)			0.340359	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			6,755,999	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			15,364,172	6.00	
7.00	Medicaid cost (line 1 times line 6)			5,229,334	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)			0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00	
Uncompensated care (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			0	19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility			5,854,368	0	5,854,368
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)			1,992,587	0	1,992,587
22.00	Partial payment by patients approved for charity care			0	0	0
23.00	Cost of charity care (line 21 minus line 22)			1,992,587	0	1,992,587
				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
26.00	Total bad debt expense for the entire hospital complex (see instructions)					7,369,680
27.00	Medicare bad debts for the entire hospital complex (see instructions)					219,230
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)					7,150,450
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)					2,433,720
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)					4,426,307
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)					4,426,307

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 150001		Period: From 01/01/2013 To 12/31/2013		Worksheet A	
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		1,949,858	1,949,858	0	1,949,858	1.00
1.01	00101		86,509	86,509	0	86,509	1.01
2.00	00200		2,451,250	2,451,250	11,495	2,462,745	2.00
4.00	00400	363,105	8,163,583	8,526,688	195,503	8,722,191	4.00
4.01	00401	212,464	285,187	497,651	0	497,651	4.01
4.02	00402	737,707	644,651	1,382,358	0	1,382,358	4.02
4.03	00403	262,754	82,332	345,086	0	345,086	4.03
4.04	00404	623,367	26,958	650,325	0	650,325	4.04
4.05	00405	927,595	572,922	1,500,517	0	1,500,517	4.05
5.00	00500	2,093,698	5,492,275	7,585,973	0	7,585,973	5.00
7.00	00700	685,847	2,024,403	2,710,250	0	2,710,250	7.00
8.00	00800	129,402	80,198	209,600	0	209,600	8.00
9.00	00900	703,800	114,901	818,701	0	818,701	9.00
10.00	01000	867,669	314,779	1,182,448	-642,408	540,040	10.00
11.00	01100	0	0	0	642,408	642,408	11.00
13.00	01300	1,107,478	163,316	1,270,794	0	1,270,794	13.00
14.00	01400	100,161	85,203	185,364	0	185,364	14.00
15.00	01500	494,588	3,994,184	4,488,772	0	4,488,772	15.00
16.00	01600	581,884	260,303	842,187	0	842,187	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	3,514,446	443,306	3,957,752	-197,765	3,759,987	30.00
31.00	03100	1,148,312	251,483	1,399,795	0	1,399,795	31.00
41.00	04100	776,235	163,105	939,340	0	939,340	41.00
43.00	04300	0	0	0	197,765	197,765	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,808,174	845,495	2,653,669	0	2,653,669	50.00
53.00	05300	0	21,896	21,896	0	21,896	53.00
54.00	05400	2,202,904	1,038,496	3,241,400	0	3,241,400	54.00
60.00	06000	1,367,278	1,918,830	3,286,108	0	3,286,108	60.00
65.00	06500	896,908	152,661	1,049,569	0	1,049,569	65.00
66.00	06600	858,100	43,959	902,059	0	902,059	66.00
67.00	06700	208,096	2,850	210,946	0	210,946	67.00
68.00	06800	134,552	3,015	137,567	0	137,567	68.00
69.00	06900	420,297	427,242	847,539	0	847,539	69.00
70.00	07000	45,331	6,711	52,042	0	52,042	70.00
71.00	07100	0	3,083,495	3,083,495	-619,526	2,463,969	71.00
72.00	07200	0	0	0	619,526	619,526	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03020	388,802	136,366	525,168	0	525,168	76.00
76.97	07697	92,386	8,124	100,510	0	100,510	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	522,383	1,562,863	2,085,246	0	2,085,246	90.00
91.00	09100	1,871,957	395,189	2,267,146	0	2,267,146	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	689,319	255,118	944,437	0	944,437	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		67,836	67,836	-11,495	56,341	113.00
118.00		26,836,999	37,620,852	64,457,851	195,503	64,653,354	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	60,665	90,738	151,403	0	151,403	190.00
192.00	19200	8,665,804	2,236,413	10,902,217	0	10,902,217	192.00
192.01	19201	0	291	291	0	291	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	85,675	7,676	93,351	0	93,351	192.03
193.00	19300	0	0	0	0	0	193.00
193.01	19301	541,699	80,485	622,184	-195,503	426,681	193.01
193.02	19302	0	0	0	0	0	193.02
193.03	19303	0	1,019,827	1,019,827	0	1,019,827	193.03
194.00	07950	10,700	11,189	21,889	0	21,889	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	146,897	250	147,147	0	147,147	194.03
194.04	07954	133,189	27,890	161,079	0	161,079	194.04
200.00		36,481,628	41,095,611	77,577,239	0	77,577,239	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150001

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

Worksheet A
Date/Time Prepared:
5/27/2014 6:07 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,331	1,948,527	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER	0	86,509	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	2,462,745	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-208,386	8,513,805	4.00
4.01	00401	COMMUNICATIONS	-35,952	461,699	4.01
4.02	00402	DATA PROCESSING	0	1,382,358	4.02
4.03	00403	MATERIALS MANAGEMENT	0	345,086	4.03
4.04	00404	ADMINISTRATIVE	0	650,325	4.04
4.05	00405	PATIENT ACCOUNTING	0	1,500,517	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	-763,452	6,822,521	5.00
7.00	00700	OPERATION OF PLANT	-53,405	2,656,845	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	209,600	8.00
9.00	00900	HOUSEKEEPING	0	818,701	9.00
10.00	01000	DIETARY	67	540,107	10.00
11.00	01100	CAFETERIA	-296,144	346,264	11.00
13.00	01300	NURSING ADMINISTRATION	-34	1,270,760	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	185,364	14.00
15.00	01500	PHARMACY	-441	4,488,331	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-27,442	814,745	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	3,759,987	30.00
31.00	03100	INTENSIVE CARE UNIT	-25	1,399,770	31.00
41.00	04100	SUBPROVIDER - I RF	-3,508	935,832	41.00
43.00	04300	NURSERY	0	197,765	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-38,277	2,615,392	50.00
53.00	05300	ANESTHESIOLOGY	0	21,896	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-38,263	3,203,137	54.00
60.00	06000	LABORATORY	0	3,286,108	60.00
65.00	06500	RESPIRATORY THERAPY	-7,000	1,042,569	65.00
66.00	06600	PHYSICAL THERAPY	0	902,059	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	210,946	67.00
68.00	06800	SPEECH PATHOLOGY	0	137,567	68.00
69.00	06900	ELECTROCARDIOLOGY	-58,570	788,969	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	52,042	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,463,969	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	619,526	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020	ONCOLOGY	132,500	657,668	76.00
76.97	07697	CARDIAC REHABILITATION	0	100,510	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-172,245	1,913,001	90.00
91.00	09100	EMERGENCY	-174,126	2,093,020	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	-965	943,472	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-56,341	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,803,340	62,850,014	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	151,403	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,902,217	192.00
192.01	19201	SOUTH CLINIC	0	291	192.01
192.02	19202	WEST CLINIC	0	0	192.02
192.03	19203	DIABETES CENTER	0	93,351	192.03
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	426,681	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	1,019,827	193.03
194.00	07950	PARTNERSHIP HFC	0	21,889	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	194.01
194.02	07952	EDINBURGH	0	0	194.02
194.03	07953	JAIL	0	147,147	194.03
194.04	07954	ATHLETIC TRAINERS	0	161,079	194.04
200.00		TOTAL (SUM OF LINES 118-199)	-1,803,340	75,773,899	200.00

RECLASSIFICATIONS

Provider CCN: 150001

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

Worksheet A-6

Date/Time Prepared:
5/27/2014 6:07 pm

		Increases			
Cost Center		Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	471,393	171,015	1.00
	TOTALS		471,393	171,015	
B - CHILD CARE					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	170,213	25,290	1.00
	TOTALS		170,213	25,290	
C - NURSERY					
1.00	NURSERY	43.00	168,245	29,520	1.00
	TOTALS		168,245	29,520	
D - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	619,526	1.00
	TOTALS		0	619,526	
E - INTEREST EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	11,495	1.00
	TOTALS		0	11,495	
500.00	Grand Total: Increases		809,851	856,846	500.00

Provider CCN: 150001

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

Worksheet A-6
Date/Time Prepared:
5/27/2014 6:07 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA							
1.00	DIETARY	10.00	471,393	171,015	0		1.00
	TOTALS		471,393	171,015			
B - CHILD CARE							
1.00	ADULT/CHILD CARE	193.01	170,213	25,290	0		1.00
	TOTALS		170,213	25,290			
C - NURSERY							
1.00	ADULTS & PEDIATRICS	30.00	168,245	29,520	0		1.00
	TOTALS		168,245	29,520			
D - IMPLANTABLE DEVICES							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	619,526	0		1.00
	TOTALS		0	619,526			
E - INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	11,495	11		1.00
	TOTALS		0	11,495			
500.00	Grand Total: Decreases		809,851	856,846			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150001

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

Worksheet A-7
Part I
Date/Time Prepared:
5/27/2014 6:07 pm

	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	3,141,963	0	0	0	1.00
2.00	Land Improvements	1,555,451	48,993	0	48,993	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	67,418,310	2,760,065	0	2,760,065	4.00
5.00	Fixed Equipment	11,142,011	268,027	0	268,027	5.00
6.00	Movable Equipment	33,847,125	4,303,818	0	4,303,818	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	117,104,860	7,380,903	0	7,380,903	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	117,104,860	7,380,903	0	7,380,903	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,141,963	0			1.00
2.00	Land Improvements	1,604,444	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	65,603,416	0			4.00
5.00	Fixed Equipment	11,410,038	0			5.00
6.00	Movable Equipment	36,763,492	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	118,523,353	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	118,523,353	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150001

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

Worksheet A-7
Part II
Date/Time Prepared:
5/27/2014 6:07 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	1,949,858	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	86,509	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	2,451,250	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,487,617	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	1,949,858				1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0	86,509				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,451,250				2.00
3.00	Total (sum of lines 1-2)	0	4,487,617				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150001

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

Worksheet A-7
Part III
Date/Time Prepared:
5/27/2014 6:07 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	81,759,861	0	81,759,861	0.689821	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0	0	0	0.000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	36,763,492	0	36,763,492	0.310179	0	2.00
3.00	Total (sum of lines 1-2)	118,523,353	0	118,523,353	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of col. 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	1,948,527	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0	0	0	86,509	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,451,250	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,486,286	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of col. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,948,527	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0	0	0	0	86,509	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	11,495	0	0	0	2,462,745	2.00
3.00	Total (sum of lines 1-2)	11,495	0	0	0	4,497,781	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150001

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

Worksheet A-8

Date/Time Prepared:
5/27/2014 6:07 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7	Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01 Investment income - CAP REL COSTS-BLDG & FIXT - TOWER (chapter 2)			0	CAP REL COSTS-BLDG & FIXT - TOWER	1.01	0	1.01
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			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	-604,173				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1		0			0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests			0		0.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts			0		0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01 Depreciation - CAP REL COSTS-BLDG & FIXT - TOWER			0	CAP REL COSTS-BLDG & FIXT - TOWER	1.01	0	26.01
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

Provider CCN: 150001

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

Worksheet A-8

Date/Time Prepared:
 5/27/2014 6:07 pm

31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		68.00	31.00
				Cost Center	Line #		
32.00	CAH HIT Adjustment for Depreciation and Interest		0			0	32.00
33.00	JMH PAIN CARE CENTER REV OPERATING F	B	-172,245	CLINIC	90.00	0	33.00
34.00	JMH NUTR SVCS DISCOUNTS OPERATING FU	B	67	DIETARY	10.00	0	34.00
35.00	JMH PURCHASES DISCOUNTS OPERATING FU	B	-5,759	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	JMH SALE OF FILM	B	-34,518	RADIOLOGY-DIAGNOSTIC	54.00	0	36.00
37.00	JMH CAFETERIA REV OPERATING FUND	B	-296,144	CAFETERIA	11.00	0	37.00
39.00	JMH MISC PHARM REVENUE OPERATING FUN	B	-441	PHARMACY	15.00	0	39.00
40.00	JMH RENT OF SPACE	B	-4,320	OPERATION OF PLANT	7.00	0	40.00
41.00	JMH MEDICAL RECORD FEES OPERATING FU	B	-27,442	MEDICAL RECORDS & LIBRARY	16.00	0	41.00
42.00	JMH GEN ACCOUNTING REV OPERATING FUN	B	-4,451	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	JMH RETURNED CHECK FEES OPERATING FU	B	-275	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	JMH EDUCATION PROGRAMS OPERATING FUN	B	-34	NURSING ADMINISTRATIVE	13.00	0	44.00
45.01	MED STAFF OTHER EXP	A	-1,060	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02	CABLE SERVICES	A	-21,902	OPERATION OF PLANT	7.00	0	45.02
45.03	TELEPHONE SERVICES	A	-1,331	CAP REL COSTS-BLDG & FIXT	1.00	9	45.03
45.04	TELEPHONE SERVICES	A	-19,271	ADMINISTRATIVE & GENERAL	5.00	0	45.04
45.05	COMMUNICATIONS	A	-35,952	COMMUNICATIONS	4.01	0	45.05
45.06	ADVERTISING EXP-A&G	A	-272,149	ADMINISTRATIVE & GENERAL	5.00	0	45.06
45.08	ADVERTISING EXP -ARU	A	-1,847	SUBPROVIDER - IRF	41.00	0	45.08
45.09	ADVERTISING EXP-BARIATRIC	A	-986	OPERATING ROOM	50.00	0	45.09
45.10	ADVERTISING EXP-RADIOLOGY	A	-745	RADIOLOGY-DIAGNOSTIC	54.00	0	45.10
45.12	ADVERTISING EXP-HHA	A	-965	HOME HEALTH AGENCY	101.00	0	45.12
45.13	DAYCARE	B	-200,780	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.13
45.14	LOBBYING EXPENSE-AHA	A	-3,789	ADMINISTRATIVE & GENERAL	5.00	0	45.14
45.15	LOBBYING EXPENSE-IHHA	A	-1,698	ADMINISTRATIVE & GENERAL	5.00	0	45.15
45.16	PROF - BUILDING	A	-27,183	OPERATION OF PLANT	7.00	0	45.16
45.17	PROF - BUILDING	A	-7,606	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.17
45.19	INTEREST INCOME	B	-56,341	INTEREST EXPENSE	113.00	0	45.19
45.20			0		0.00	0	45.20
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,803,340				50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150001

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

Worksheet A-8-2

Date/Time Prepared:
5/27/2014 6:07 pm

	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	455,000	455,000	0	225,300	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	2,895	25	2,870	225,300	48	2.00
3.00	41.00	SUBPROVIDER - IRF	108,570	0	108,570	225,300	987	3.00
4.00	50.00	OPERATING ROOM	41,082	30,082	11,000	225,300	35	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	3,000	3,000	0	225,300	0	5.00
6.00	60.00	LABORATORY	110,004	0	110,004	215,700	1,593	6.00
7.00	65.00	RESPIRATORY THERAPY	7,000	7,000	0	225,300	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	58,570	58,570	0	225,300	0	8.00
9.00	76.00	ONCOLOGY	-132,500	-132,500	0	225,300	0	9.00
10.00	91.00	EMERGENCY	180,269	174,126	6,143	225,300	95	10.00
200.00			833,890	595,303	238,587		2,758	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	5,199	260	0	0	0	2.00
3.00	41.00	SUBPROVIDER - IRF	106,909	5,345	0	0	0	3.00
4.00	50.00	OPERATING ROOM	3,791	190	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	165,197	8,260	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	76.00	ONCOLOGY	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	10,290	515	0	0	0	10.00
200.00			291,386	14,570	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	455,000	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	5,199	0	25	2.00
3.00	41.00	SUBPROVIDER - IRF	0	106,909	1,661	1,661	3.00
4.00	50.00	OPERATING ROOM	0	3,791	7,209	37,291	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	3,000	5.00
6.00	60.00	LABORATORY	0	165,197	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	7,000	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	58,570	8.00
9.00	76.00	ONCOLOGY	0	0	0	-132,500	9.00
10.00	91.00	EMERGENCY	0	10,290	0	174,126	10.00
200.00			0	291,386	8,870	604,173	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150001

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

Worksheet B
Part I
Date/Time Prepared:
5/27/2014 6:07 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	BLDG & FIXT - TOWER	MVBLE EQUIP		
	0	1.00	1.01	2.00	4.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,948,527	1,948,527			1.00
1.01 00101	CAP REL COSTS-BLDG & FIXT - TOWER	86,509	0	86,509		1.01
2.00 00200	CAP REL COSTS-MVBLE EQUIP	2,462,745			2,462,745	2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	8,513,805	19,670	0	1,990	8,535,465
4.01 00401	COMMUNICATIONS	461,699	2,591	0	0	50,447
4.02 00402	DATA PROCESSING	1,382,358	28,029	0	1,010,274	175,159
4.03 00403	MATERIALS MANAGEMENT	345,086	25,221	0	5,217	62,388
4.04 00404	ADMITTING	650,325	29,017	1,798	0	148,010
4.05 00405	PATIENT ACCOUNTING	1,500,517	17,772	0	1,879	220,245
5.00 00500	ADMINISTRATIVE & GENERAL	6,822,521	64,376	0	10,909	497,121
7.00 00700	OPERATION OF PLANT	2,656,845	169,385	12,373	32,796	162,845
8.00 00800	LAUNDRY & LINEN SERVICE	209,600	15,847	0	4,333	30,725
9.00 00900	HOUSEKEEPING	818,701	12,300	917	2,259	167,108
10.00 01000	DIETARY	540,107	24,054	247	20,091	94,091
11.00 01100	CAFETERIA	346,264	27,495	0	0	111,926
13.00 01300	NURSING ADMINISTRATION	1,270,760	67,066	0	30,156	262,956
14.00 01400	CENTRAL SERVICES & SUPPLY	185,364	11,200	0	32,146	23,782
15.00 01500	PHARMACY	4,488,331	13,487	0	3,686	117,433
16.00 01600	MEDICAL RECORDS & LIBRARY	814,745	30,303	594	6,100	138,161
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	3,759,987	278,342	25,542	178,411	794,512
31.00 03100	INTENSIVE CARE UNIT	1,399,770	15,583	2,599	84,067	272,652
41.00 04100	SUBPROVIDER - I/R	935,832	53,289	8,887	13,556	184,307
43.00 04300	NURSERY	197,765	4,120	0	0	39,948
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	2,615,392	301,201	710	416,497	429,327
53.00 05300	ANESTHESIOLOGY	21,896	2,597	0	26,917	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,203,137	108,977	11,802	245,607	523,051
60.00 06000	LABORATORY	3,286,108	44,522	6,774	102,379	324,642
65.00 06500	RESPIRATORY THERAPY	1,042,569	22,241	1,177	25,028	212,959
66.00 06600	PHYSICAL THERAPY	902,059	44,370	0	7,687	203,745
67.00 06700	OCCUPATIONAL THERAPY	210,946	8,800	0	3,097	49,410
68.00 06800	SPEECH PATHOLOGY	137,567	804	134	325	31,948
69.00 06900	ELECTROCARDIOLOGY	788,969	25,280	97	52,787	99,794
70.00 07000	ELECTROENCEPHALOGRAPHY	52,042	1,450	242	4,125	10,763
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,463,969	0	0	19,171	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	619,526	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00 03020	ONCOLOGY	657,668	71,463	0	5,948	92,316
76.97 07697	CARDIAC REHABILITATION	100,510	16,552	0	2,802	21,936
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	1,913,001	75,912	485	29,039	124,033
91.00 09100	EMERGENCY	2,093,020	70,085	11,689	56,648	444,472
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	943,472	14,687	0	872	163,670
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	62,850,014	1,718,088	86,067	2,436,799	6,285,882
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	151,403	4,700	0	2,210	14,404
192.00 19200	PHYSICIANS' PRIVATE OFFICES	10,902,217	181,877	0	23,574	2,057,588
192.01 19201	SOUTH CLINIC	291	0	0	162	0
192.02 19202	WEST CLINIC	0	0	0	0	0
192.03 19203	DIABETES CENTER	93,351	2,650	442	0	20,342
193.00 19300	NONPAID WORKERS	0	0	0	0	0
193.01 19301	ADULT/CHILD CARE	426,681	32,610	0	0	88,205
193.02 19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0
193.03 19303	OPTIFAST/FOUNDATION	1,019,827	0	0	0	0
194.00 07950	PARTNERSHIP HFC	21,889	8,602	0	0	2,541
194.01 07951	TRAFALGAR CLINIC	0	0	0	0	0
194.02 07952	EDINBURGH	0	0	0	0	0
194.03 07953	JAIL	147,147	0	0	0	34,879
194.04 07954	ATHLETIC TRAINERS	161,079	0	0	0	31,624
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	75,773,899	1,948,527	86,509	2,462,745	8,535,465

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150001

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

Worksheet B
Part I
Date/Time Prepared:
5/27/2014 6:07 pm

Cost Center Description			COMMUNICATIONS	DATA PROCESSING	MATERIALS MANAGEMENT	ADMINITTING	PATIENT ACCOUNTING	
			4.01	4.02	4.03	4.04	4.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS	514,737					4.01
4.02	00402	DATA PROCESSING	60,604	2,656,424				4.02
4.03	00403	MATERIALS MANAGEMENT	8,772	37,192	483,876			4.03
4.04	00404	ADMINITTING	8,373	141,329	1,805	980,657		4.04
4.05	00405	PATIENT ACCOUNTING	31,100	277,079	4,726	0	2,053,318	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	32,296	283,587	16,605	0	0	5.00
7.00	00700	OPERATION OF PLANT	15,151	20,455	164	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,994	8,368	1,229	0	0	8.00
9.00	00900	HOUSEKEEPING	4,386	0	7,320	0	0	9.00
10.00	01000	DIETARY	9,968	69,735	567	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	14,752	73,454	2,640	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	4,406	0	0	14.00
15.00	01500	PHARMACY	6,778	13,017	7,071	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16,347	92,050	223	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	46,251	230,589	14,842	71,110	148,883	30.00
31.00	03100	INTENSIVE CARE UNIT	11,164	80,892	3,651	12,070	25,272	31.00
41.00	04100	SUBPROVIDER - I RF	6,379	59,507	1,565	12,652	26,490	41.00
43.00	04300	NURSERY	0	0	0	3,095	6,480	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	32,296	214,783	33,993	143,239	299,900	50.00
53.00	05300	ANESTHESIOLOGY	0	0	97	13,959	29,225	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,733	137,610	21,895	197,092	412,765	54.00
60.00	06000	LABORATORY	27,112	116,224	80,262	146,481	306,688	60.00
65.00	06500	RESPIRATORY THERAPY	6,379	56,717	7,675	32,503	68,051	65.00
66.00	06600	PHYSICAL THERAPY	8,373	54,858	1,632	18,976	39,731	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,595	17,666	21	10,745	22,497	67.00
68.00	06800	SPEECH PATHOLOGY	1,595	6,509	0	3,268	6,842	68.00
69.00	06900	ELECTROCARDIOLOGY	14,354	36,262	4,661	31,819	66,620	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	797	3,719	40	611	1,279	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	226,885	45,248	94,735	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,428	21,834	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	74,138	155,224	73.00
76.00	03020	ONCOLOGY	14,752	42,771	1,532	13,595	28,464	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	330	1,311	2,744	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	7,177	68,805	17,086	37,125	77,728	90.00
91.00	09100	EMERGENCY	22,328	94,839	5,899	92,225	193,091	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	8,373	62,296	1,406	8,967	18,775	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	440,179	2,300,313	470,228	980,657	2,053,318	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,386	12,087	65	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	61,001	277,079	13,140	0	0	192.00
192.01	19201	SOUTH CLINIC	0	0	22	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	1,196	5,579	18	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	5,981	26,034	270	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	1,994	35,332	110	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	23	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	514,737	2,656,424	483,876	980,657	2,053,318	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150001

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4A. 05	5. 00	7. 00	8. 00	9. 00	
GENERAL SERVICE COST CENTERS							
1. 00	00100	CAP REL COSTS-BLDG & FIXT					1. 00
1. 01	00101	CAP REL COSTS-BLDG & FIXT - TOWER					1. 01
2. 00	00200	CAP REL COSTS-MVBLE EQUIP					2. 00
4. 00	00400	EMPLOYEE BENEFITS DEPARTMENT					4. 00
4. 01	00401	COMMUNICATIONS					4. 01
4. 02	00402	DATA PROCESSING					4. 02
4. 03	00403	MATERIALS MANAGEMENT					4. 03
4. 04	00404	ADMINISTRATIVE					4. 04
4. 05	00405	PATIENT ACCOUNTING					4. 05
5. 00	00500	ADMINISTRATIVE & GENERAL	7,727,415	7,727,415			5. 00
7. 00	00700	OPERATION OF PLANT	3,070,014	348,634	3,418,648		7. 00
8. 00	00800	LAUNDRY & LINEN SERVICE	272,096	30,899	34,019	337,014	8. 00
9. 00	00900	HOUSEKEEPING	1,012,991	115,036	26,406	45,630	1,200,063
10. 00	01000	DIETARY	758,860	86,177	51,638	5,987	18,453
11. 00	01100	CAFETERIA	485,685	55,155	59,025	0	21,093
13. 00	01300	NURSING ADMINISTRATION	1,721,784	195,528	143,974	0	51,449
14. 00	01400	CENTRAL SERVICES & SUPPLY	256,898	29,174	24,043	0	8,592
15. 00	01500	PHARMACY	4,649,803	528,036	28,953	0	10,347
16. 00	01600	MEDICAL RECORDS & LIBRARY	1,098,523	124,749	65,053	0	23,247
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00	03000	ADULTS & PEDIATRICS	5,548,469	630,090	597,535	109,996	213,529
31. 00	03100	INTENSIVE CARE UNIT	1,907,720	216,643	33,453	22,423	11,955
41. 00	04100	SUBPROVIDER - I RF	1,302,464	147,909	114,398	15,634	40,880
43. 00	04300	NURSERY	251,408	28,550	8,845	0	3,161
ANCILLARY SERVICE COST CENTERS							
50. 00	05000	OPERATING ROOM	4,487,338	509,587	646,611	51,905	231,066
53. 00	05300	ANESTHESIOLOGY	94,691	10,753	5,576	0	1,992
54. 00	05400	RADIOLOGY-DIAGNOSTIC	4,882,669	554,481	233,948	22,190	83,601
60. 00	06000	LABORATORY	4,441,192	504,346	95,577	0	34,155
65. 00	06500	RESPIRATORY THERAPY	1,475,299	167,536	47,746	0	17,062
66. 00	06600	PHYSICAL THERAPY	1,281,431	145,521	95,252	3,139	34,038
67. 00	06700	OCCUPATIONAL THERAPY	324,777	36,882	18,892	0	6,751
68. 00	06800	SPEECH PATHOLOGY	188,992	21,462	1,726	0	617
69. 00	06900	ELECTROCARDIOLOGY	1,120,643	127,261	54,270	4,154	19,393
70. 00	07000	ELECTROENCEPHALOGRAPHY	75,068	8,525	3,113	0	1,113
71. 00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,850,008	323,650	0	0	0
72. 00	07200	IMPL. DEV. CHARGED TO PATIENTS	651,788	74,018	0	0	0
73. 00	07300	DRUGS CHARGED TO PATIENTS	229,362	26,047	0	0	0
76. 00	03020	ONCOLOGY	928,509	105,442	153,413	0	54,822
76. 97	07697	CARDIAC REHABILITATION	146,185	16,601	35,534	0	12,698
OUTPATIENT SERVICE COST CENTERS							
90. 00	09000	CLINIC	2,350,391	266,913	162,965	3,144	58,236
91. 00	09100	EMERGENCY	3,084,296	350,256	150,456	47,555	53,765
92. 00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0				
OTHER REIMBURSABLE COST CENTERS							
101. 00	10100	HOME HEALTH AGENCY	1,222,518	138,830	31,529	0	11,267
SPECIAL PURPOSE COST CENTERS							
113. 00	11300	INTEREST EXPENSE					
118. 00		SUBTOTALS (SUM OF LINES 1-117)	59,899,287	5,924,691	2,923,950	331,757	1,023,282
NONREIMBURSABLE COST CENTERS							
190. 00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	189,255	21,492	10,090	0	3,606
192. 00	19200	PHYSICIANS' PRIVATE OFFICES	13,516,476	1,534,931	390,446	5,257	139,526
192. 01	19201	SOUTH CLINIC	475	54	0	0	0
192. 02	19202	WEST CLINIC	0	0	0	0	0
192. 03	19203	DIABETES CENTER	123,578	14,034	5,689	0	2,033
193. 00	19300	NONPAID WORKERS	0	0	0	0	0
193. 01	19301	ADULT/CHILD CARE	579,781	65,841	70,006	0	25,017
193. 02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0
193. 03	19303	OPTIFAST/FOUNDATION	1,019,827	115,813	0	0	0
194. 00	07950	PARTNERSHIP HFC	70,468	8,002	18,467	0	6,599
194. 01	07951	TRAFALGAR CLINIC	0	0	0	0	0
194. 02	07952	EDINBURGH	0	0	0	0	0
194. 03	07953	JAIL	182,026	20,671	0	0	0
194. 04	07954	ATHLETIC TRAINERS	192,726	21,886	0	0	0
200. 00		Cross Foot Adjustments	0				
201. 00		Negative Cost Centers	0	0	0	0	0
202. 00		TOTAL (sum lines 118-201)	75,773,899	7,727,415	3,418,648	337,014	1,200,063

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150001	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part I Date/Time Prepared: 5/27/2014 6:07 pm
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
4.01	00401						4.01
4.02	00402						4.02
4.03	00403						4.03
4.04	00404						4.04
4.05	00405						4.05
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	921,115					10.00
11.00	01100	0	620,958				11.00
13.00	01300	0	14,301	2,127,036			13.00
14.00	01400	0	4,040	0	322,747		14.00
15.00	01500	0	9,691	0	0	5,226,830	15.00
16.00	01600	0	22,733	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	595,668	92,207	849,785	0	0	30.00
31.00	03100	92,013	28,244	260,300	0	0	31.00
41.00	04100	174,001	19,852	182,960	0	0	41.00
43.00	04300	59,433	4,126	38,030	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	45,265	398,135	0	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	52,499	0	0	0	54.00
60.00	06000	0	44,600	0	0	0	60.00
65.00	06500	0	21,515	0	0	0	65.00
66.00	06600	0	19,803	0	0	0	66.00
67.00	06700	0	4,699	0	0	0	67.00
68.00	06800	0	2,567	0	0	0	68.00
69.00	06900	0	8,835	0	0	0	69.00
70.00	07000	0	1,216	0	0	0	70.00
71.00	07100	0	0	0	322,747	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	5,226,830	73.00
76.00	03020	0	9,488	0	0	0	76.00
76.97	07697	0	1,990	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	16,935	0	0	0	90.00
91.00	09100	0	43,496	397,826	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	16,916	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		921,115	485,018	2,127,036	322,747	5,226,830	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	2,335	0	0	0	190.00
192.00	19200	0	100,892	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	0	1,955	0	0	0	192.03
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	20,966	0	0	0	193.01
193.02	19302	0	0	0	0	0	193.02
193.03	19303	0	0	0	0	0	193.03
194.00	07950	0	3,918	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	1,589	0	0	0	194.03
194.04	07954	0	4,285	0	0	0	194.04
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		921,115	620,958	2,127,036	322,747	5,226,830	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150001

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.01	00401	COMMUNICATIONS					4.01
4.02	00402	DATA PROCESSING					4.02
4.03	00403	MATERIALS MANAGEMENT					4.03
4.04	00404	ADMINISTRATIVE					4.04
4.05	00405	PATIENT ACCOUNTING					4.05
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,334,305				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	96,749	8,734,028	0	8,734,028	30.00
31.00	03100	INTENSIVE CARE UNIT	16,423	2,589,174	0	2,589,174	31.00
41.00	04100	SUBPROVIDER - IIRF	17,214	2,015,312	0	2,015,312	41.00
43.00	04300	NURSERY	4,211	397,764	0	397,764	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	194,886	6,564,793	0	6,564,793	50.00
53.00	05300	ANESTHESIOLOGY	18,992	132,004	0	132,004	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	268,215	6,097,603	0	6,097,603	54.00
60.00	06000	LABORATORY	199,297	5,319,167	0	5,319,167	60.00
65.00	06500	RESPIRATORY THERAPY	44,222	1,773,380	0	1,773,380	65.00
66.00	06600	PHYSICAL THERAPY	25,818	1,605,002	0	1,605,002	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,620	406,621	0	406,621	67.00
68.00	06800	SPEECH PATHOLOGY	4,446	219,810	0	219,810	68.00
69.00	06900	ELECTROCARDIOLOGY	43,292	1,377,848	0	1,377,848	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	831	89,866	0	89,866	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	61,562	3,557,967	0	3,557,967	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,188	739,994	0	739,994	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100,870	5,583,109	0	5,583,109	73.00
76.00	03020	ONCOLOGY	18,497	1,270,171	0	1,270,171	76.00
76.97	07697	CARDIAC REHABILITATION	1,783	214,791	0	214,791	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	50,510	2,909,094	0	2,909,094	90.00
91.00	09100	EMERGENCY	125,478	4,253,128	0	4,253,128	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	12,201	1,433,261	0	1,433,261	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,334,305	57,283,887	0	57,283,887	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	226,778	0	226,778	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,687,528	0	15,687,528	192.00
192.01	19201	SOUTH CLINIC	0	529	0	529	192.01
192.02	19202	WEST CLINIC	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	0	147,289	0	147,289	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	761,611	0	761,611	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	1,135,640	0	1,135,640	193.03
194.00	07950	PARTNERSHIP HFC	0	107,454	0	107,454	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	194.02
194.03	07953	JAIL	0	204,286	0	204,286	194.03
194.04	07954	ATHLETIC TRAINERS	0	218,897	0	218,897	194.04
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,334,305	75,773,899	0	75,773,899	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150001

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
			BLDG & FIXT	BLDG & FIXT - TOWER	MVBLE EQUIP		
			0	1.00	1.01		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	19,670	0	1,990	21,660
4.01	00401	COMMUNICATIONS	0	2,591	0	0	2,591
4.02	00402	DATA PROCESSING	0	28,029	0	1,010,274	1,038,303
4.03	00403	MATERIALS MANAGEMENT	0	25,221	0	5,217	30,438
4.04	00404	ADMINISTRATIVE	0	29,017	1,798	0	30,815
4.05	00405	PATIENT ACCOUNTING	0	17,772	0	1,879	19,651
5.00	00500	ADMINISTRATIVE & GENERAL	0	64,376	0	10,909	75,285
7.00	00700	OPERATION OF PLANT	0	169,385	12,373	32,796	214,554
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,847	0	4,333	20,180
9.00	00900	HOUSEKEEPING	0	12,300	917	2,259	15,476
10.00	01000	DIETARY	0	24,054	247	20,091	44,392
11.00	01100	CAFETERIA	0	27,495	0	0	27,495
13.00	01300	NURSING ADMINISTRATION	0	67,066	0	30,156	97,222
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,200	0	32,146	43,346
15.00	01500	PHARMACY	0	13,487	0	3,686	17,173
16.00	01600	MEDICAL RECORDS & LIBRARY	0	30,303	594	6,100	36,997
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	278,342	25,542	178,411	482,295
31.00	03100	INTENSIVE CARE UNIT	0	15,583	2,599	84,067	102,249
41.00	04100	SUBPROVIDER - IRF	0	53,289	8,887	13,556	75,732
43.00	04300	NURSERY	0	4,120	0	0	4,120
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	301,201	710	416,497	718,408
53.00	05300	ANESTHESIOLOGY	0	2,597	0	26,917	29,514
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	108,977	11,802	245,607	366,386
60.00	06000	LABORATORY	0	44,522	6,774	102,379	153,675
65.00	06500	RESPIRATORY THERAPY	0	22,241	1,177	25,028	48,446
66.00	06600	PHYSICAL THERAPY	0	44,370	0	7,687	52,057
67.00	06700	OCCUPATIONAL THERAPY	0	8,800	0	3,097	11,897
68.00	06800	SPEECH PATHOLOGY	0	804	134	325	1,263
69.00	06900	ELECTROCARDIOLOGY	0	25,280	97	52,787	78,164
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,450	242	4,125	5,817
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	19,171	19,171
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03020	ONCOLOGY	0	71,463	0	5,948	77,411
76.97	07697	CARDIAC REHABILITATION	0	16,552	0	2,802	19,354
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	75,912	485	29,039	105,436
91.00	09100	EMERGENCY	0	70,085	11,689	56,648	138,422
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	14,687	0	872	15,559
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,718,088	86,067	2,436,799	4,240,954
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,700	0	2,210	6,910
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	181,877	0	23,574	205,451
192.01	19201	SOUTH CLINIC	0	0	0	162	162
192.02	19202	WEST CLINIC	0	0	0	0	0
192.03	19203	DIABETES CENTER	0	2,650	442	0	3,092
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	ADULT/CHILD CARE	0	32,610	0	0	32,610
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0
194.00	07950	PARTNERSHIP HFC	0	8,602	0	0	8,602
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0
194.02	07952	EDINBURGH	0	0	0	0	0
194.03	07953	JAIL	0	0	0	0	0
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	0	1,948,527	86,509	2,462,745	4,497,781

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150001

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	DATA PROCESSING	MATERIALS MANAGEMENT	ADMINISTRATIVE	
		4.00	4.01	4.02	4.03	4.04	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	21,660				4.00
4.01	00401	COMMUNICATIONS	128	2,719			4.01
4.02	00402	DATA PROCESSING	445	320	1,039,068		4.02
4.03	00403	MATERIALS MANAGEMENT	158	46	14,548	45,190	4.03
4.04	00404	ADMINISTRATIVE	376	44	55,281	169	86,685
4.05	00405	PATIENT ACCOUNTING	559	164	108,380	441	0
5.00	00500	ADMINISTRATIVE & GENERAL	1,262	171	110,927	1,551	0
7.00	00700	OPERATION OF PLANT	414	80	8,001	15	0
8.00	00800	LAUNDRY & LINEN SERVICE	78	11	3,273	115	0
9.00	00900	HOUSEKEEPING	424	23	0	684	0
10.00	01000	DIETARY	239	53	27,277	53	0
11.00	01100	CAFETERIA	284	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	668	78	28,732	247	0
14.00	01400	CENTRAL SERVICES & SUPPLY	60	0	0	411	0
15.00	01500	PHARMACY	298	36	5,092	660	0
16.00	01600	MEDICAL RECORDS & LIBRARY	351	86	36,006	21	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,018	244	90,196	1,386	6,285
31.00	03100	INTENSIVE CARE UNIT	692	59	31,641	341	1,067
41.00	04100	SUBPROVIDER - IRF	468	34	23,276	146	1,118
43.00	04300	NURSERY	101	0	0	0	274
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,090	171	84,013	3,175	12,660
53.00	05300	ANESTHESIOLOGY	0	0	0	9	1,234
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,328	110	53,826	2,045	17,430
60.00	06000	LABORATORY	824	143	45,461	7,495	12,946
65.00	06500	RESPIRATORY THERAPY	541	34	22,185	717	2,873
66.00	06600	PHYSICAL THERAPY	517	44	21,458	152	1,677
67.00	06700	OCCUPATIONAL THERAPY	125	8	6,910	2	950
68.00	06800	SPEECH PATHOLOGY	81	8	2,546	0	289
69.00	06900	ELECTROCARDIOLOGY	253	76	14,184	435	2,812
70.00	07000	ELECTROENCEPHALOGRAPHY	27	4	1,455	4	54
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	21,190	3,999
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	922
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	6,552
76.00	03020	ONCOLOGY	234	78	16,730	143	1,202
76.97	07697	CARDIAC REHABILITATION	56	0	0	31	116
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	315	38	26,913	1,596	3,281
91.00	09100	EMERGENCY	1,129	118	37,097	551	8,151
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	416	44	24,367	131	793
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,959	2,325	899,775	43,916	86,685
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	37	23	4,728	6	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,213	322	108,380	1,227	0
192.01	19201	SOUTH CLINIC	0	0	0	2	0
192.02	19202	WEST CLINIC	0	0	0	0	0
192.03	19203	DIABETES CENTER	52	6	2,182	2	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	ADULT/CHILD CARE	224	32	10,183	25	0
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0
193.03	19303	OPTI FAST/FOUNDATION	0	0	0	0	0
194.00	07950	PARTNERSHIP HFC	6	11	13,820	10	0
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0
194.02	07952	EDINBURGH	0	0	0	0	0
194.03	07953	JAIL	89	0	0	0	0
194.04	07954	ATHLETIC TRAINERS	80	0	0	2	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)	21,660	2,719	1,039,068	45,190	86,685

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150001

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		PATIENT ACCOUNTING	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4.05	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
4.01	00401						4.01
4.02	00402						4.02
4.03	00403						4.03
4.04	00404						4.04
4.05	00405						4.05
5.00	00500	129,195	0				5.00
7.00	00700	0	189,196				7.00
8.00	00800	0	8,535	231,599			8.00
9.00	00900	0	756	2,305	26,718		9.00
10.00	01000	0	2,816	1,789	3,617	24,829	10.00
11.00	01100	0	2,110	3,498	475	382	11.00
13.00	01300	0	1,350	3,999	0	436	13.00
14.00	01400	0	4,787	9,754	0	1,064	14.00
15.00	01500	0	714	1,629	0	178	15.00
16.00	01600	0	12,926	1,961	0	214	16.00
		0	3,054	4,407	0	481	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	9,372	15,425	40,480	8,721	4,418	30.00
31.00	03100	1,591	5,303	2,266	1,778	247	31.00
41.00	04100	1,668	3,621	7,750	1,239	846	41.00
43.00	04300	408	699	599	0	65	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	18,879	12,475	43,804	4,115	4,780	50.00
53.00	05300	1,840	263	378	0	41	53.00
54.00	05400	25,920	13,574	15,849	1,759	1,730	54.00
60.00	06000	19,306	12,347	6,475	0	707	60.00
65.00	06500	4,284	4,101	3,235	0	353	65.00
66.00	06600	2,501	3,562	6,453	249	704	66.00
67.00	06700	1,416	903	1,280	0	140	67.00
68.00	06800	431	525	117	0	13	68.00
69.00	06900	4,194	3,115	3,677	329	401	69.00
70.00	07000	81	209	211	0	23	70.00
71.00	07100	5,964	7,923	0	0	0	71.00
72.00	07200	1,374	1,812	0	0	0	72.00
73.00	07300	9,771	638	0	0	0	73.00
76.00	03020	1,792	2,581	10,393	0	1,134	76.00
76.97	07697	173	406	2,407	0	263	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	4,893	6,534	11,040	249	1,205	90.00
91.00	09100	12,155	8,574	10,193	3,770	1,112	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	1,182	3,399	2,136	0	233	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		129,195	145,037	198,085	26,301	21,170	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	526	684	0	75	190.00
192.00	19200	0	37,603	26,451	417	2,887	192.00
192.01	19201	0	1	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	0	344	385	0	42	192.03
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	1,612	4,743	0	518	193.01
193.02	19302	0	0	0	0	0	193.02
193.03	19303	0	2,835	0	0	0	193.03
194.00	07950	0	196	1,251	0	137	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	506	0	0	0	194.03
194.04	07954	0	536	0	0	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		129,195	189,196	231,599	26,718	24,829	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150001	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 5/27/2014 6:07 pm
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
4.01	00401						4.01
4.02	00402						4.02
4.03	00403						4.03
4.04	00404						4.04
4.05	00405						4.05
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	78,479					10.00
11.00	01100	0	33,564				11.00
13.00	01300	0	773	143,325			13.00
14.00	01400	0	218	0	46,556		14.00
15.00	01500	0	524	0	0	38,884	15.00
16.00	01600	0	1,229	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	50,750	4,984	57,261	0	0	30.00
31.00	03100	7,840	1,527	17,540	0	0	31.00
41.00	04100	14,825	1,073	12,328	0	0	41.00
43.00	04300	5,064	223	2,563	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	2,447	26,827	0	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	2,838	0	0	0	54.00
60.00	06000	0	2,411	0	0	0	60.00
65.00	06500	0	1,163	0	0	0	65.00
66.00	06600	0	1,070	0	0	0	66.00
67.00	06700	0	254	0	0	0	67.00
68.00	06800	0	139	0	0	0	68.00
69.00	06900	0	478	0	0	0	69.00
70.00	07000	0	66	0	0	0	70.00
71.00	07100	0	0	0	46,556	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	38,884	73.00
76.00	03020	0	513	0	0	0	76.00
76.97	07697	0	108	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	915	0	0	0	90.00
91.00	09100	0	2,351	26,806	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	914	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		78,479	26,218	143,325	46,556	38,884	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	126	0	0	0	190.00
192.00	19200	0	5,451	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	0	106	0	0	0	192.03
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	1,133	0	0	0	193.01
193.02	19302	0	0	0	0	0	193.02
193.03	19303	0	0	0	0	0	193.03
194.00	07950	0	212	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	86	0	0	0	194.03
194.04	07954	0	232	0	0	0	194.04
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		78,479	33,564	143,325	46,556	38,884	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150001

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

Worksheet B
Part II
Date/Time Prepared:
5/27/2014 6:07 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.01	00401	COMMUNICATIONS					4.01
4.02	00402	DATA PROCESSING					4.02
4.03	00403	MATERIALS MANAGEMENT					4.03
4.04	00404	ADMINISTRATIVE					4.04
4.05	00405	PATIENT ACCOUNTING					4.05
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	82,632				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,992	779,827	0	779,827	30.00
31.00	03100	INTENSIVE CARE UNIT	1,017	175,158	0	175,158	31.00
41.00	04100	SUBPROVIDER - IRF	1,066	145,190	0	145,190	41.00
43.00	04300	NURSERY	261	14,377	0	14,377	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	12,070	944,914	0	944,914	50.00
53.00	05300	ANESTHESIOLOGY	1,176	34,455	0	34,455	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,607	519,402	0	519,402	54.00
60.00	06000	LABORATORY	12,343	274,133	0	274,133	60.00
65.00	06500	RESPIRATORY THERAPY	2,739	90,671	0	90,671	65.00
66.00	06600	PHYSICAL THERAPY	1,599	92,043	0	92,043	66.00
67.00	06700	OCCUPATIONAL THERAPY	905	24,790	0	24,790	67.00
68.00	06800	SPEECH PATHOLOGY	275	5,687	0	5,687	68.00
69.00	06900	ELECTROCARDIOLOGY	2,681	110,799	0	110,799	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	51	8,002	0	8,002	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,813	108,616	0	108,616	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	879	4,987	0	4,987	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,247	62,092	0	62,092	73.00
76.00	03020	ONCOLOGY	1,146	113,357	0	113,357	76.00
76.97	07697	CARDIAC REHABILITATION	110	23,024	0	23,024	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,128	165,543	0	165,543	90.00
91.00	09100	EMERGENCY	7,771	258,200	0	258,200	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	756	49,930	0	49,930	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	82,632	4,005,197	0	4,005,197	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,115	0	13,115	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	393,402	0	393,402	192.00
192.01	19201	SOUTH CLINIC	0	165	0	165	192.01
192.02	19202	WEST CLINIC	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	0	6,211	0	6,211	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	51,080	0	51,080	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	2,835	0	2,835	193.03
194.00	07950	PARTNERSHIP HFC	0	24,245	0	24,245	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	194.02
194.03	07953	JAIL	0	681	0	681	194.03
194.04	07954	ATHLETIC TRAINERS	0	850	0	850	194.04
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	82,632	4,497,781	0	4,497,781	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150001

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

Worksheet B-1

Date/Time Prepared:
5/27/2014 6:07 pm

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (# NON PT PHONES)	
		BLDG & FIXT (TOTAL FEET)	BLDG & FIXT - TOWER (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
		1.00	1.01	2.00			
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	295,595				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER	0	78,688			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2,451,250		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,984	0	1,981	35,948,310	4.00
4.01	00401	COMMUNICATIONS	393	0	0	212,464	4.01
4.02	00402	DATA PROCESSING	4,252	0	1,005,557	737,707	4.02
4.03	00403	MATERIALS MANAGEMENT	3,826	0	5,193	262,754	4.03
4.04	00404	ADMITTING	4,402	1,635	0	623,367	4.04
4.05	00405	PATIENT ACCOUNTING	2,696	0	1,870	927,595	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	9,766	0	10,858	2,093,698	5.00
7.00	00700	OPERATION OF PLANT	25,696	11,254	32,643	685,847	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,404	0	4,313	129,402	8.00
9.00	00900	HOUSEKEEPING	1,866	834	2,248	703,800	9.00
10.00	01000	DIETARY	3,649	225	19,997	396,276	10.00
11.00	01100	CAFETERIA	4,171	0	0	471,393	11.00
13.00	01300	NURSING ADMINISTRATION	10,174	0	30,015	1,107,478	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,699	0	31,996	100,161	14.00
15.00	01500	PHARMACY	2,046	0	3,669	494,588	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,597	540	6,072	581,884	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	42,225	23,233	177,578	3,346,201	30.00
31.00	03100	INTENSIVE CARE UNIT	2,364	2,364	83,675	1,148,312	31.00
41.00	04100	SUBPROVIDER - I/R	8,084	8,084	13,493	776,235	41.00
43.00	04300	NURSERY	625	0	0	168,245	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	45,693	646	414,553	1,808,174	50.00
53.00	05300	ANESTHESIOLOGY	394	0	26,791	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,532	10,735	244,461	2,202,904	54.00
60.00	06000	LABORATORY	6,754	6,162	101,901	1,367,278	60.00
65.00	06500	RESPIRATORY THERAPY	3,374	1,071	24,911	896,908	65.00
66.00	06600	PHYSICAL THERAPY	6,731	0	7,651	858,100	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,335	0	3,083	208,096	67.00
68.00	06800	SPEECH PATHOLOGY	122	122	323	134,552	68.00
69.00	06900	ELECTROCARDIOLOGY	3,835	88	52,541	420,297	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	220	220	4,106	45,331	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	19,082	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
76.00	03020	ONCOLOGY	10,841	0	5,920	388,802	76.00
76.97	07697	CARDIAC REHABILITATION	2,511	0	2,789	92,386	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	11,516	441	28,903	522,383	90.00
91.00	09100	EMERGENCY	10,632	10,632	56,384	1,871,957	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	2,228	0	868	689,319	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	260,637	78,286	2,425,425	26,473,894	1,104
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	713	0	2,200	60,665	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	27,591	0	23,464	8,665,804	192.00
192.01	19201	SOUTH CLINIC	0	0	161	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	402	402	0	85,675	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	4,947	0	0	371,486	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	1,305	0	0	10,700	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	146,897	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	133,189	194.04
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)	1,948,527	86,509	2,462,745	8,535,465	514,737

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150001

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

Worksheet B-1

Date/Time Prepared:
5/27/2014 6:07 pm

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (# NON PT PHONES)	
		BLDG & FIXT (TOTAL FEET)	BLDG & FIXT - TOWER (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
		1.00	1.01	2.00			
203.00	Unit cost multiplier (Wkst. B, Part I)	6.591881	1.099393	1.004689	0.237437	398.711851	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)				21,660	2,719	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)				0.000603	2.106119	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150001

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

Worksheet B-1

Date/Time Prepared:
5/27/2014 6:07 pm

Cost Center Description		DATA PROCESSING (WORK ORDERS)	MATERIALS MANAGEMENT (SUPPLY USAGE)	ADMINISTRATIVE (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	Reconciliation	
		4.02	4.03	4.04	4.05	5A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.01	00401	COMMUNICATIONS					4.01
4.02	00402	DATA PROCESSING	2,857				4.02
4.03	00403	MATERIALS MANAGEMENT	40	6,496,188			4.03
4.04	00404	ADMINISTRATIVE	152	24,236	168,304,414		4.04
4.05	00405	PATIENT ACCOUNTING	298	63,447	0	168,304,414	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	305	222,930	0	0	-7,727,415
7.00	00700	OPERATION OF PLANT	22	2,203	0	0	0
8.00	00800	LAUNDRY & LINEN SERVICE	9	16,496	0	0	0
9.00	00900	HOUSEKEEPING	0	98,270	0	0	0
10.00	01000	DIETARY	75	7,606	0	0	0
11.00	01100	CAFETERIA	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	79	35,443	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	59,154	0	0	0
15.00	01500	PHARMACY	14	94,932	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	99	2,996	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	248	199,261	12,203,497	12,203,497	0
31.00	03100	INTENSIVE CARE UNIT	87	49,010	2,071,474	2,071,474	0
41.00	04100	SUBPROVIDER - IIRF	64	21,007	2,171,287	2,171,287	0
43.00	04300	NURSERY	0	0	531,124	531,124	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	231	456,374	24,581,970	24,581,970	0
53.00	05300	ANESTHESIOLOGY	0	1,297	2,395,509	2,395,509	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	148	293,948	33,832,881	33,832,881	0
60.00	06000	LABORATORY	125	1,077,545	25,138,364	25,138,364	0
65.00	06500	RESPIRATORY THERAPY	61	103,039	5,577,976	5,577,976	0
66.00	06600	PHYSICAL THERAPY	59	21,906	3,256,620	3,256,620	0
67.00	06700	OCCUPATIONAL THERAPY	19	278	1,844,053	1,844,053	0
68.00	06800	SPEECH PATHOLOGY	7	0	560,816	560,816	0
69.00	06900	ELECTROCARDIOLOGY	39	62,569	5,460,658	5,460,658	0
70.00	07000	ELECTROENCEPHALOGRAPHY	4	532	104,856	104,856	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,046,047	7,765,192	7,765,192	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,789,669	1,789,669	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	12,723,250	12,723,250	0
76.00	03020	ONCOLOGY	46	20,562	2,333,094	2,333,094	0
76.97	07697	CARDIAC REHABILITATION	0	4,437	224,937	224,937	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	74	229,387	6,371,122	6,371,122	0
91.00	09100	EMERGENCY	102	79,200	15,827,143	15,827,143	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	67	18,880	1,538,922	1,538,922	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,474	6,312,992	168,304,414	168,304,414	-7,727,415
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13	868	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	298	176,404	0	0	0
192.01	19201	SOUTH CLINIC	0	292	0	0	0
192.02	19202	WEST CLINIC	0	0	0	0	0
192.03	19203	DIABETES CENTER	6	237	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	ADULT/CHILD CARE	28	3,619	0	0	0
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0
194.00	07950	PARTNERSHIP HFC	38	1,472	0	0	0
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0
194.02	07952	EDINBURGH	0	0	0	0	0
194.03	07953	JAIL	0	0	0	0	0
194.04	07954	ATHLETIC TRAINERS	0	304	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,656,424	483,876	980,657	2,053,318	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	929.794890	0.074486	0.005827	0.012200	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,039,068	45,190	86,685	129,195	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150001

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

Worksheet B-1

Date/Time Prepared:
5/27/2014 6:07 pm

Cost Center Description		DATA PROCESSING (WORK ORDERS)	MATERIALS MANAGEMENT (SUPPLY USAGE)	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	Reconciliation	
		4.02	4.03	4.04	4.05	5A	
205.00	Unit cost multiplier (Wkst. B, Part II)	363.691985	0.006956	0.000515	0.000768		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150001

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

Worksheet B-1

Date/Time Prepared:
5/27/2014 6:07 pm

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (TOTAL FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (TOTAL FEET)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
4.01	00401						4.01
4.02	00402						4.02
4.03	00403						4.03
4.04	00404						4.04
4.05	00405						4.05
5.00	00500	68,046,484					5.00
7.00	00700		241,580				7.00
8.00	00800			556,760			8.00
9.00	00900				237,310		9.00
10.00	01000					10,291	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	5,548,469	42,225	181,720	42,225	6,655	30.00
31.00	03100	1,907,720	2,364	37,043	2,364	1,028	31.00
41.00	04100	1,302,464	8,084	25,828	8,084	1,944	41.00
43.00	04300	251,408	625	0	625	664	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	4,487,338	45,693	85,749	45,693	0	50.00
53.00	05300	94,691	394	0	394	0	53.00
54.00	05400	4,882,669	16,532	36,658	16,532	0	54.00
60.00	06000	4,441,192	6,754	0	6,754	0	60.00
65.00	06500	1,475,299	3,374	0	3,374	0	65.00
66.00	06600	1,281,431	6,731	5,185	6,731	0	66.00
67.00	06700	324,777	1,335	0	1,335	0	67.00
68.00	06800	188,922	122	0	122	0	68.00
69.00	06900	1,120,643	3,835	6,863	3,835	0	69.00
70.00	07000	75,068	220	0	220	0	70.00
71.00	07100	2,850,008	0	0	0	0	71.00
72.00	07200	651,788	0	0	0	0	72.00
73.00	07300	229,362	0	0	0	0	73.00
76.00	03020	928,509	10,841	0	10,841	0	76.00
76.97	07697	146,185	2,511	0	2,511	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	2,350,391	11,516	5,194	11,516	0	90.00
91.00	09100	3,084,296	10,632	78,563	10,632	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	1,222,518	2,228	0	2,228	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		52,171,872	206,622	548,076	202,352	10,291	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	189,255	713	0	713	0	190.00
192.00	19200	13,516,476	27,591	8,684	27,591	0	192.00
192.01	19201	475	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	123,578	402	0	402	0	192.03
193.00	19300	0	0	0	0	0	193.00
193.01	19301	579,781	4,947	0	4,947	0	193.01
193.02	19302	0	0	0	0	0	193.02
193.03	19303	1,019,827	0	0	0	0	193.03
194.00	07950	70,468	1,305	0	1,305	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	182,026	0	0	0	0	194.03
194.04	07954	192,726	0	0	0	0	194.04
200.00							200.00
201.00							201.00
202.00		7,727,415	3,418,648	337,014	1,200,063	921,115	202.00
203.00		0.113561	14.151205	0.605313	5.056942	89.506851	203.00
204.00		189,196	231,599	26,718	24,829	78,479	204.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 150001			Period: From 01/01/2013 To 12/31/2013		Worksheet B-1 Date/Time Prepared: 5/27/2014 6:07 pm	
Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (TOTAL FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (TOTAL FEET)	DIETARY (MEALS SERVED)		
		5.00	7.00	8.00	9.00	10.00		
205.00	Unit cost multiplier (Wkst. B, Part II)	0.002780	0.958684	0.047988	0.104627	7.625984	205.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150001

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

Worksheet B-1
Date/Time Prepared:
5/27/2014 6:07 pm

Cost Center Description		CAFETERIA (HOURS PAID)	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
4.01	00401						4.01
4.02	00402						4.02
4.03	00403						4.03
4.04	00404						4.04
4.05	00405						4.05
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	870,997					11.00
13.00	01300	20,059	323,729				13.00
14.00	01400	5,667	0	100			14.00
15.00	01500	13,593	0	0	100		15.00
16.00	01600	31,887	0	0	0	168,304,414	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	129,335	129,335	0	0	12,203,497	30.00
31.00	03100	39,617	39,617	0	0	2,071,474	31.00
41.00	04100	27,846	27,846	0	0	2,171,287	41.00
43.00	04300	5,788	5,788	0	0	531,124	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	63,492	60,595	0	0	24,581,970	50.00
53.00	05300	0	0	0	0	2,395,509	53.00
54.00	05400	73,639	0	0	0	33,832,881	54.00
60.00	06000	62,559	0	0	0	25,138,364	60.00
65.00	06500	30,178	0	0	0	5,577,976	65.00
66.00	06600	27,777	0	0	0	3,256,620	66.00
67.00	06700	6,591	0	0	6,591	1,844,053	67.00
68.00	06800	3,601	0	0	0	560,816	68.00
69.00	06900	12,393	0	0	0	5,460,658	69.00
70.00	07000	1,705	0	0	0	104,856	70.00
71.00	07100	0	0	100	0	7,765,192	71.00
72.00	07200	0	0	0	0	1,789,669	72.00
73.00	07300	0	0	0	100	12,723,250	73.00
76.00	03020	13,309	0	0	0	2,333,094	76.00
76.97	07697	2,791	0	0	0	224,937	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	23,754	0	0	0	6,371,122	90.00
91.00	09100	61,010	60,548	0	0	15,827,143	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	23,727	0	0	0	1,538,922	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		680,318	323,729	100	100	168,304,414	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	3,275	0	0	0	0	190.00
192.00	19200	141,518	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	2,742	0	0	0	0	192.03
193.00	19300	0	0	0	0	0	193.00
193.01	19301	29,409	0	0	0	0	193.01
193.02	19302	0	0	0	0	0	193.02
193.03	19303	0	0	0	0	0	193.03
194.00	07950	5,496	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	2,229	0	0	0	0	194.03
194.04	07954	6,010	0	0	0	0	194.04
200.00							200.00
201.00							201.00
202.00		620,958	2,127,036	322,747	5,226,830	1,334,305	202.00
203.00		0.712928	6.570422	3,227.470000	52,268.300000	0.007928	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150001

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		CAFETERIA (HOURS PAID)	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	33,564	143,325	46,556	38,884	82,632	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.038535	0.442731	465.560000	388.840000	0.000491	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150001

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

Worksheet C
Part I
Date/Time Prepared:
5/27/2014 6:07 pm

		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		8,734,028	0	8,734,028	30.00	
31.00	03100 INTENSIVE CARE UNIT		2,589,174	0	2,589,174	31.00	
41.00	04100 SUBPROVIDER - I RF		2,015,312	1,661	2,016,973	41.00	
43.00	04300 NURSERY		397,764	0	397,764	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		6,564,793	7,209	6,572,002	50.00	
53.00	05300 ANESTHESIOLOGY		132,004	0	132,004	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		6,097,603	0	6,097,603	54.00	
60.00	06000 LABORATORY		5,319,167	0	5,319,167	60.00	
65.00	06500 RESPIRATORY THERAPY	0	1,773,380	0	1,773,380	65.00	
66.00	06600 PHYSICAL THERAPY	0	1,605,002	0	1,605,002	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	406,621	0	406,621	67.00	
68.00	06800 SPEECH PATHOLOGY	0	219,810	0	219,810	68.00	
69.00	06900 ELECTROCARDIOLOGY		1,377,848	0	1,377,848	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY		89,866	0	89,866	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		3,557,967	0	3,557,967	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		739,994	0	739,994	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		5,583,109	0	5,583,109	73.00	
76.00	03020 ONCOLOGY		1,270,171	0	1,270,171	76.00	
76.97	07697 CARDIAC REHABILITATION		214,791	0	214,791	76.97	
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC		2,909,094	0	2,909,094	90.00	
91.00	09100 EMERGENCY		4,253,128	0	4,253,128	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		1,377,372		1,377,372	92.00	
OTHER REIMBURSABLE COST CENTERS							
101.00	10100 HOME HEALTH AGENCY		1,433,261		1,433,261	101.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE					113.00	
200.00	Subtotal (see instructions)		58,661,259	0	58,661,259	200.00	
201.00	Less Observation Beds		1,377,372		1,377,372	201.00	
202.00	Total (see instructions)		57,283,887	0	57,283,887	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150001

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

Worksheet C
Part I
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Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	10,452,593		10,452,593		30.00
31.00	03100	INTENSIVE CARE UNIT	2,071,474		2,071,474		31.00
41.00	04100	SUBPROVIDER - IRF	2,171,287		2,171,287		41.00
43.00	04300	NURSERY	531,124		531,124		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,505,142	20,076,828	24,581,970	0.267057	50.00
53.00	05300	ANESTHESIOLOGY	518,606	1,876,903	2,395,509	0.055105	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,139,832	29,693,049	33,832,881	0.180227	54.00
60.00	06000	LABORATORY	6,409,820	18,728,544	25,138,364	0.211596	60.00
65.00	06500	RESPIRATORY THERAPY	3,143,136	2,434,840	5,577,976	0.317925	65.00
66.00	06600	PHYSICAL THERAPY	1,289,026	1,967,594	3,256,620	0.492843	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,282,708	561,345	1,844,053	0.220504	67.00
68.00	06800	SPEECH PATHOLOGY	290,972	269,844	560,816	0.391947	68.00
69.00	06900	ELECTROCARDIOLOGY	1,548,347	3,912,311	5,460,658	0.252323	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	24,581	80,275	104,856	0.857042	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,819,354	4,945,838	7,765,192	0.458194	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,789,669	1,789,669	0.413481	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,525,835	8,197,415	12,723,250	0.438812	73.00
76.00	03020	ONCOLOGY	33,444	2,299,650	2,333,094	0.544415	76.00
76.97	07697	CARDIAC REHABILITATION	600	224,337	224,937	0.954894	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	16,985	6,354,137	6,371,122	0.456606	90.00
91.00	09100	EMERGENCY	2,459,309	13,367,834	15,827,143	0.268724	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	386,425	1,364,479	1,750,904	0.786663	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	1,538,922	1,538,922		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	48,620,600	119,683,814	168,304,414		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	48,620,600	119,683,814	168,304,414		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150001	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/27/2014 6:07 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.267351		50.00
53.00	05300 ANESTHESIOLOGY	0.055105		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.180227		54.00
60.00	06000 LABORATORY	0.211596		60.00
65.00	06500 RESPIRATORY THERAPY	0.317925		65.00
66.00	06600 PHYSICAL THERAPY	0.492843		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.220504		67.00
68.00	06800 SPEECH PATHOLOGY	0.391947		68.00
69.00	06900 ELECTROCARDIOLOGY	0.252323		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.857042		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.458194		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.413481		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.438812		73.00
76.00	03020 ONCOLOGY	0.544415		76.00
76.97	07697 CARDIAC REHABILITATION	0.954894		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.456606		90.00
91.00	09100 EMERGENCY	0.268724		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.786663		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150001

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

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Part I
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		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		8,734,028	0	8,734,028	30.00
31.00	03100 INTENSIVE CARE UNIT		2,589,174	0	2,589,174	31.00
41.00	04100 SUBPROVIDER - I RF		2,015,312	1,661	2,016,973	41.00
43.00	04300 NURSERY		397,764	0	397,764	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		6,564,793	7,209	6,572,002	50.00
53.00	05300 ANESTHESIOLOGY		132,004	0	132,004	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		6,097,603	0	6,097,603	54.00
60.00	06000 LABORATORY		5,319,167	0	5,319,167	60.00
65.00	06500 RESPIRATORY THERAPY	0	1,773,380	0	1,773,380	65.00
66.00	06600 PHYSICAL THERAPY	0	1,605,002	0	1,605,002	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	406,621	0	406,621	67.00
68.00	06800 SPEECH PATHOLOGY	0	219,810	0	219,810	68.00
69.00	06900 ELECTROCARDIOLOGY		1,377,848	0	1,377,848	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		89,866	0	89,866	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		3,557,967	0	3,557,967	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		739,994	0	739,994	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		5,583,109	0	5,583,109	73.00
76.00	03020 ONCOLOGY		1,270,171	0	1,270,171	76.00
76.97	07697 CARDIAC REHABILITATION		214,791	0	214,791	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		2,909,094	0	2,909,094	90.00
91.00	09100 EMERGENCY		4,253,128	0	4,253,128	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		1,377,372		1,377,372	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY		1,433,261		1,433,261	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		58,661,259	0	58,661,259	200.00
201.00	Less Observation Beds		1,377,372		1,377,372	201.00
202.00	Total (see instructions)		57,283,887	0	57,283,887	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150001

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

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XIX Hospital Cost							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	10,452,593		10,452,593		30.00
31.00	03100	INTENSIVE CARE UNIT	2,071,474		2,071,474		31.00
41.00	04100	SUBPROVIDER - IRF	2,171,287		2,171,287		41.00
43.00	04300	NURSERY	531,124		531,124		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,505,142	20,076,828	24,581,970	0.267057	50.00
53.00	05300	ANESTHESIOLOGY	518,606	1,876,903	2,395,509	0.055105	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,139,832	29,693,049	33,832,881	0.180227	54.00
60.00	06000	LABORATORY	6,409,820	18,728,544	25,138,364	0.211596	60.00
65.00	06500	RESPIRATORY THERAPY	3,143,136	2,434,840	5,577,976	0.317925	65.00
66.00	06600	PHYSICAL THERAPY	1,289,026	1,967,594	3,256,620	0.492843	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,282,708	561,345	1,844,053	0.220504	67.00
68.00	06800	SPEECH PATHOLOGY	290,972	269,844	560,816	0.391947	68.00
69.00	06900	ELECTROCARDIOLOGY	1,548,347	3,912,311	5,460,658	0.252323	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	24,581	80,275	104,856	0.857042	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,819,354	4,945,838	7,765,192	0.458194	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,789,669	1,789,669	0.413481	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,525,835	8,197,415	12,723,250	0.438812	73.00
76.00	03020	ONCOLOGY	33,444	2,299,650	2,333,094	0.544415	76.00
76.97	07697	CARDIAC REHABILITATION	600	224,337	224,937	0.954894	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	16,985	6,354,137	6,371,122	0.456606	90.00
91.00	09100	EMERGENCY	2,459,309	13,367,834	15,827,143	0.268724	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	386,425	1,364,479	1,750,904	0.786663	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	1,538,922	1,538,922		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	48,620,600	119,683,814	168,304,414		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	48,620,600	119,683,814	168,304,414		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150001

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

Worksheet C
Part I
Date/Time Prepared:
5/27/2014 6:07 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	ONCOLOGY	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 150001

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

Worksheet C
Part II
Date/Time Prepared:
5/27/2014 6:07 pm

Cost Center Description		Title XIX			Hospital		Operating Cost Reduction Amount	
		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	6,564,793	944,914	5,619,879	0	0	50.00
53.00	05300	ANESTHESIOLOGY	132,004	34,455	97,549	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,097,603	519,402	5,578,201	0	0	54.00
60.00	06000	LABORATORY	5,319,167	274,133	5,045,034	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,773,380	90,671	1,682,709	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,605,002	92,043	1,512,959	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	406,621	24,790	381,831	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	219,810	5,687	214,123	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,377,848	110,799	1,267,049	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	89,866	8,002	81,864	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,557,967	108,616	3,449,351	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	739,994	4,987	735,007	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,583,109	62,092	5,521,017	0	0	73.00
76.00	03020	ONCOLOGY	1,270,171	113,357	1,156,814	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	214,791	23,024	191,767	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,909,094	165,543	2,743,551	0	0	90.00
91.00	09100	EMERGENCY	4,253,128	258,200	3,994,928	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,377,372	122,980	1,254,392	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,433,261	49,930	1,383,331	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	44,924,981	3,013,625	41,911,356	0	0	200.00
201.00		Less Observation Beds	1,377,372	122,980	1,254,392	0	0	201.00
202.00		Total (line 200 minus line 201)	43,547,609	2,890,645	40,656,964	0	0	202.00

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

Provider CCN: 150001

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

Worksheet C
Part II
Date/Time Prepared:
5/27/2014 6:07 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital Cost
		6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	6,564,793	24,581,970	0.267057	50.00
53.00	05300 ANESTHESIOLOGY	132,004	2,395,509	0.055105	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	6,097,603	33,832,881	0.180227	54.00
60.00	06000 LABORATORY	5,319,167	25,138,364	0.211596	60.00
65.00	06500 RESPIRATORY THERAPY	1,773,380	5,577,976	0.317925	65.00
66.00	06600 PHYSICAL THERAPY	1,605,002	3,256,620	0.492843	66.00
67.00	06700 OCCUPATIONAL THERAPY	406,621	1,844,053	0.220504	67.00
68.00	06800 SPEECH PATHOLOGY	219,810	560,816	0.391947	68.00
69.00	06900 ELECTROCARDIOLOGY	1,377,848	5,460,658	0.252323	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	89,866	104,856	0.857042	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3,557,967	7,765,192	0.458194	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	739,994	1,789,669	0.413481	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	5,583,109	12,723,250	0.438812	73.00
76.00	03020 ONCOLOGY	1,270,171	2,333,094	0.544415	76.00
76.97	07697 CARDIAC REHABILITATION	214,791	224,937	0.954894	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	2,909,094	6,371,122	0.456606	90.00
91.00	09100 EMERGENCY	4,253,128	15,827,143	0.268724	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,377,372	1,750,904	0.786663	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100 HOME HEALTH AGENCY	1,433,261	1,538,922	0.931341	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (sum of lines 50 thru 199)	44,924,981	153,077,936		200.00
201.00	Less Observation Beds	1,377,372	0		201.00
202.00	Total (line 200 minus line 201)	43,547,609	153,077,936		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150001	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part I Date/Time Prepared: 5/27/2014 6:07 pm
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Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	779,827	0	779,827	7,920	98.46	30.00
31.00	INTENSIVE CARE UNIT	175,158	0	175,158	1,028	170.39	31.00
41.00	SUBPROVIDER - IRF	145,190	0	145,190	1,944	74.69	41.00
43.00	NURSERY	14,377		14,377	664	21.65	43.00
200.00	Total (Lines 30-199)	1,114,552		1,114,552	11,556		200.00

Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
	6.00	7.00	

INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	3,326	327,478	30.00
31.00	INTENSIVE CARE UNIT	339	57,762	31.00
41.00	SUBPROVIDER - IRF	1,273	95,080	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (Lines 30-199)	4,938	480,320	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150001	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/27/2014 6:07 pm
		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	944,914	24,581,970	0.038439	1,625,456	62,481	50.00
53.00	05300	ANESTHESIOLOGY	34,455	2,395,509	0.014383	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	519,402	33,832,881	0.015352	2,059,784	31,622	54.00
60.00	06000	LABORATORY	274,133	25,138,364	0.010905	3,303,370	36,023	60.00
65.00	06500	RESPIRATORY THERAPY	90,671	5,577,976	0.016255	1,444,186	23,475	65.00
66.00	06600	PHYSICAL THERAPY	92,043	3,256,620	0.028263	312,249	8,825	66.00
67.00	06700	OCCUPATIONAL THERAPY	24,790	1,844,053	0.013443	284,394	3,823	67.00
68.00	06800	SPEECH PATHOLOGY	5,687	560,816	0.010141	76,069	771	68.00
69.00	06900	ELECTROCARDIOLOGY	110,799	5,460,658	0.020290	950,584	19,287	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,002	104,856	0.076314	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	108,616	7,765,192	0.013988	1,289,894	18,043	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,987	1,789,669	0.002787	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	62,092	12,723,250	0.004880	2,416,307	11,792	73.00
76.00	03020	ONCOLOGY	113,357	2,333,094	0.048587	17,831	866	76.00
76.97	07697	CARDIAC REHABILITATION	23,024	224,937	0.102358	408	42	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	165,543	6,371,122	0.025983	6,314	164	90.00
91.00	09100	EMERGENCY	258,200	15,827,143	0.016314	1,067,355	17,413	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	122,980	1,750,904	0.070238	0	0	92.00
200.00		Total (lines 50-199)	2,963,695	151,539,014		14,854,201	234,627	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150001		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part III Date/Time Prepared: 5/27/2014 6:07 pm	
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	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
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	7,920	0.00	3,326	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,028	0.00	339	0		31.00
41.00	04100	SUBPROVIDER - IRF	1,944	0.00	1,273	0		41.00
43.00	04300	NURSERY	664	0.00	0	0		43.00
200.00		Total (lines 30-199)	11,556		4,938	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150001	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/27/2014 6:07 pm
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Cost Center Description		Title XVIII				Hospital	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03020	ONCOLOGY	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150001	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/27/2014 6:07 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	24,581,970	0.000000	0.000000	1,625,456	50.00
53.00	05300 ANESTHESIOLOGY	0	2,395,509	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	33,832,881	0.000000	0.000000	2,059,784	54.00
60.00	06000 LABORATORY	0	25,138,364	0.000000	0.000000	3,303,370	60.00
65.00	06500 RESPIRATORY THERAPY	0	5,577,976	0.000000	0.000000	1,444,186	65.00
66.00	06600 PHYSICAL THERAPY	0	3,256,620	0.000000	0.000000	312,249	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,844,053	0.000000	0.000000	284,394	67.00
68.00	06800 SPEECH PATHOLOGY	0	560,816	0.000000	0.000000	76,069	68.00
69.00	06900 ELECTROCARDIOLOGY	0	5,460,658	0.000000	0.000000	950,584	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	104,856	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,765,192	0.000000	0.000000	1,289,894	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1,789,669	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	12,723,250	0.000000	0.000000	2,416,307	73.00
76.00	03020 ONCOLOGY	0	2,333,094	0.000000	0.000000	17,831	76.00
76.97	07697 CARDIAC REHABILITATION	0	224,937	0.000000	0.000000	408	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	6,371,122	0.000000	0.000000	6,314	90.00
91.00	09100 EMERGENCY	0	15,827,143	0.000000	0.000000	1,067,355	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1,750,904	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	151,539,014			14,854,201	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150001	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/27/2014 6:07 pm
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)	
ANCILLARY SERVICE COST CENTERS			11.00	12.00	13.00	
50.00	05000	OPERATING ROOM	0	4,434,808	0	50.00
53.00	05300	ANESTHESIOLOGY	0	746,151	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,401,700	0	54.00
60.00	06000	LABORATORY	0	278,324	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	213,731	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,928	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,048,910	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	939,510	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,053,477	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,519,500	0	73.00
76.00	03020	ONCOLOGY	0	585,418	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	89,080	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,836,883	0	90.00
91.00	09100	EMERGENCY	0	2,378,155	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	352,119	0	92.00
200.00		Total (lines 50-199)	0	26,879,694	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150001	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 6:07 pm
		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	0.267057	4,434,808	0	0	1,184,347 50.00
53.00	05300 ANESTHESIOLOGY	0.055105	746,151	0	0	41,117 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.180227	7,401,700	0	0	1,333,986 54.00
60.00	06000 LABORATORY	0.211596	278,324	8,842	0	58,892 60.00
65.00	06500 RESPIRATORY THERAPY	0.317925	213,731	55	0	67,950 65.00
66.00	06600 PHYSICAL THERAPY	0.492843	0	0	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.220504	1,928	0	0	425 67.00
68.00	06800 SPEECH PATHOLOGY	0.391947	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.252323	2,048,910	0	0	516,987 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.857042	0	0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.458194	939,510	0	0	430,478 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.413481	1,053,477	0	0	435,593 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.438812	4,519,500	0	3,816	1,983,211 73.00
76.00	03020 ONCOLOGY	0.544415	585,418	0	0	318,710 76.00
76.97	07697 CARDIAC REHABILITATION	0.954894	89,080	0	0	85,062 76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.456606	1,836,883	0	0	838,732 90.00
91.00	09100 EMERGENCY	0.268724	2,378,155	0	0	639,067 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.786663	352,119	0	0	276,999 92.00
200.00	Subtotal (see instructions)		26,879,694	8,897	3,816	8,211,556 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		26,879,694	8,897	3,816	8,211,556 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150001	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 6:07 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00 06000 LABORATORY	1,871	0		60.00
65.00 06500 RESPIRATORY THERAPY	17	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
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1,675		73.00
76.00 03020 ONCOLOGY	0	0		76.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
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)	1,888	1,675		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	1,888	1,675		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150001 Component CCN: 15T001		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part II Date/Time Prepared: 5/27/2014 6:07 pm		
		Title XVIII		Subprovider - IRF		PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	944,914	24,581,970	0.038439	4,299	165	50.00
53.00	05300	ANESTHESIOLOGY	34,455	2,395,509	0.014383	951	14	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	519,402	33,832,881	0.015352	80,310	1,233	54.00
60.00	06000	LABORATORY	274,133	25,138,364	0.010905	265,160	2,892	60.00
65.00	06500	RESPIRATORY THERAPY	90,671	5,577,976	0.016255	124,106	2,017	65.00
66.00	06600	PHYSICAL THERAPY	92,043	3,256,620	0.028263	527,873	14,919	66.00
67.00	06700	OCCUPATIONAL THERAPY	24,790	1,844,053	0.013443	553,266	7,438	67.00
68.00	06800	SPEECH PATHOLOGY	5,687	560,816	0.010141	88,608	899	68.00
69.00	06900	ELECTROCARDIOLOGY	110,799	5,460,658	0.020290	22,317	453	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,002	104,856	0.076314	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	108,616	7,765,192	0.013988	19,699	276	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,987	1,789,669	0.002787	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	62,092	12,723,250	0.004880	163,821	799	73.00
76.00	03020	ONCOLOGY	113,357	2,333,094	0.048587	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	23,024	224,937	0.102358	136	14	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	165,543	6,371,122	0.025983	178	5	90.00
91.00	09100	EMERGENCY	258,200	15,827,143	0.016314	5,586	91	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,750,904	0.000000	0	0	92.00
200.00		Total (lines 50-199)	2,840,715	151,539,014		1,856,310	31,215	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150001 Component CCN: 15T001	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/27/2014 6:07 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
	1.00	2.00	3.00	4.00	5.00	
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
60.00 06000 LABORATORY	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
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
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00 03020 ONCOLOGY	0	0	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
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: 150001 Component CCN: 15T001	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/27/2014 6:07 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	24,581,970	0.000000	0.000000	4,299	50.00
53.00	05300 ANESTHESIOLOGY	0	2,395,509	0.000000	0.000000	951	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	33,832,881	0.000000	0.000000	80,310	54.00
60.00	06000 LABORATORY	0	25,138,364	0.000000	0.000000	265,160	60.00
65.00	06500 RESPIRATORY THERAPY	0	5,577,976	0.000000	0.000000	124,106	65.00
66.00	06600 PHYSICAL THERAPY	0	3,256,620	0.000000	0.000000	527,873	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,844,053	0.000000	0.000000	553,266	67.00
68.00	06800 SPEECH PATHOLOGY	0	560,816	0.000000	0.000000	88,608	68.00
69.00	06900 ELECTROCARDIOLOGY	0	5,460,658	0.000000	0.000000	22,317	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	104,856	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,765,192	0.000000	0.000000	19,699	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1,789,669	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	12,723,250	0.000000	0.000000	163,821	73.00
76.00	03020 ONCOLOGY	0	2,333,094	0.000000	0.000000	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	224,937	0.000000	0.000000	136	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	6,371,122	0.000000	0.000000	178	90.00
91.00	09100 EMERGENCY	0	15,827,143	0.000000	0.000000	5,586	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1,750,904	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	151,539,014			1,856,310	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150001 Component CCN: 15T001	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/27/2014 6:07 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description			Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
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
60.00	06000	LABORATORY	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03020	ONCOLOGY	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	240	0	90.00
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	240	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150001 Component CCN: 15T001	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 6:07 pm
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			PPS Services (see inst.)	PPS Services (see inst.)
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.267057	0	0	0	0	50.00
53.00 05300 ANESTHESIOLOGY	0.055105	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.180227	0	0	0	0	54.00
60.00 06000 LABORATORY	0.211596	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.317925	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.492843	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.220504	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.391947	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.252323	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.857042	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.458194	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.413481	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.438812	0	0	744	0	73.00
76.00 03020 ONCOLOGY	0.544415	0	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0.954894	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.456606	240	0	0	110	90.00
91.00 09100 EMERGENCY	0.268724	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.786663	0	0	0	0	92.00
200.00 Subtotal (see instructions)		240	0	744	110	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		240	0	744	110	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150001 Component CCN: 15T001	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 6:07 pm
	Title XVIII	Subprovider - IRF	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
60.00 06000 LABORATORY	0	0		60.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
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
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	326		73.00
76.00 03020 ONCOLOGY	0	0		76.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
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	326		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	326		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150001	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 6:07 pm
	Title XIX	Hospital	Cost

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	0.267057	0	945,314	0	0
53.00 05300 ANESTHESIOLOGY	0.055105	0	90,856	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.180227	0	1,355,721	0	0
60.00 06000 LABORATORY	0.211596	0	797,488	0	0
65.00 06500 RESPIRATORY THERAPY	0.317925	0	110,837	0	0
66.00 06600 PHYSICAL THERAPY	0.492843	0	53,304	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.220504	0	48,196	0	0
68.00 06800 SPEECH PATHOLOGY	0.391947	0	50,867	0	0
69.00 06900 ELECTROCARDIOLOGY	0.252323	0	109,501	0	0
70.00 07000 ELECTROENCEPHALOGRAPHY	0.857042	0	5,757	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.458194	0	228,362	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.413481	0	82,633	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.438812	0	276,421	0	0
76.00 03020 ONCOLOGY	0.544415	0	77,229	0	0
76.97 07697 CARDIAC REHABILITATION	0.954894	0	3,148	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0.456606	0	0	0	0
91.00 09100 EMERGENCY	0.268724	0	0	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.786663	0	0	0	0
200.00 Subtotal (see instructions)		0	4,235,634	0	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00 Net Charges (line 200 +/- line 201)		0	4,235,634	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150001	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 6:07 pm
		Title XIX	Hospital	Cost

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	252,453	0	50.00
53.00	05300 ANESTHESIOLOGY	5,007	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	244,338	0	54.00
60.00	06000 LABORATORY	168,745	0	60.00
65.00	06500 RESPIRATORY THERAPY	35,238	0	65.00
66.00	06600 PHYSICAL THERAPY	26,271	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	10,627	0	67.00
68.00	06800 SPEECH PATHOLOGY	19,937	0	68.00
69.00	06900 ELECTROCARDIOLOGY	27,630	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	4,934	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	104,634	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	34,167	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	121,297	0	73.00
76.00	03020 ONCOLOGY	42,045	0	76.00
76.97	07697 CARDIAC REHABILITATION	3,006	0	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
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)	1,100,329	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	1,100,329	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150001	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/27/2014 6:07 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,920	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,920	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		6,671	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		3,326	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		8,734,028	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		8,734,028	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		8,734,028	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)		1,102.78	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,667,846	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)		3,667,846	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150001		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 5/27/2014 6:07 pm	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	2,589,174	1,028	2,518.65	339	853,822		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					4,401,319		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					8,922,987		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)					385,240		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					234,627		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					619,867		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					8,303,120		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)					1,249		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,102.78		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,377,372		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150001		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/27/2014 6:07 pm	
		Title XVIII		Hospital		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	779,827	8,734,028	0.089286	1,377,372	122,980	90.00
91.00	Nursing School cost	0	8,734,028	0.000000	1,377,372	0	91.00
92.00	Allied health cost	0	8,734,028	0.000000	1,377,372	0	92.00
93.00	All other Medical Education	0	8,734,028	0.000000	1,377,372	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150001 Component CCN: 15T001	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/27/2014 6:07 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,944 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,944 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)			1,944 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			1,273 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			2,016,973 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,016,973 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			2,016,973 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)			1,037.54 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,320,788 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)			1,320,788 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150001		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
		Component CCN: 15T001				Date/Time Prepared: 5/27/2014 6:07 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					616,380		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,937,168		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)					95,080		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					31,215		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					126,295		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,810,873		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150001 Component CCN: 15T001		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/27/2014 6:07 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	145,190	2,016,973	0.071984	0	0	90.00
91.00	Nursing School cost	0	2,016,973	0.000000	0	0	91.00
92.00	Allied health cost	0	2,016,973	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,016,973	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150001	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/27/2014 6:07 pm
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,920	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,920	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		6,671	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		370	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)		664	15.00
16.00	Nursery days (title V or XIX only)		39	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		8,734,028	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		8,734,028	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		8,734,028	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)		1,102.78	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		408,029	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)		408,029	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150001		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/27/2014 6:07 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
NURSERY (title V & XIX only)		397,764	664	599.04	39	23,363	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	2,589,174	1,028	2,518.65	27	68,004	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)					449,386	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					948,782	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,249	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,102.78	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,377,372	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150001		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/27/2014 6:07 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150001 Component CCN: 15T001	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/27/2014 6:07 pm
		Title XIX	Subprovider - IRF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,944 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,944 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)			1,944 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			258 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)			664 15.00
16.00	Nursery days (title V or XIX only)			39 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			2,015,312 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,015,312 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			2,015,312 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)			1,036.68 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			267,463 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)			267,463 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150001		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
		Component CCN: 15T001				Date/Time Prepared: 5/27/2014 6:07 pm	
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					28,059		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					295,522		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150001 Component CCN: 15T001		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/27/2014 6:07 pm	
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital -related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150001	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/27/2014 6:07 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		4,270,592	30.00
31.00	03100	INTENSIVE CARE UNIT		640,644	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.267351	1,625,456	50.00
53.00	05300	ANESTHESIOLOGY	0.055105	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180227	2,059,784	54.00
60.00	06000	LABORATORY	0.211596	3,303,370	60.00
65.00	06500	RESPIRATORY THERAPY	0.317925	1,444,186	65.00
66.00	06600	PHYSICAL THERAPY	0.492843	312,249	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.220504	284,394	67.00
68.00	06800	SPEECH PATHOLOGY	0.391947	76,069	68.00
69.00	06900	ELECTROCARDIOLOGY	0.252323	950,584	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.857042	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.458194	1,289,894	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.413481	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.438812	2,416,307	73.00
76.00	03020	ONCOLOGY	0.544415	17,831	76.00
76.97	07697	CARDIAC REHABILITATION	0.954894	408	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.456606	6,314	90.00
91.00	09100	EMERGENCY	0.268724	1,067,355	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.786663	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		14,854,201	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)		14,854,201	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150001 Component CCN: 15T001	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/27/2014 6:07 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
41.00	04100 SUBPROVIDER - IRF		1,411,626	41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.267351	4,299	1,149 50.00
53.00	05300 ANESTHESIOLOGY	0.055105	951	52 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.180227	80,310	14,474 54.00
60.00	06000 LABORATORY	0.211596	265,160	56,107 60.00
65.00	06500 RESPIRATORY THERAPY	0.317925	124,106	39,456 65.00
66.00	06600 PHYSICAL THERAPY	0.492843	527,873	260,159 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.220504	553,266	121,997 67.00
68.00	06800 SPEECH PATHOLOGY	0.391947	88,608	34,730 68.00
69.00	06900 ELECTROCARDIOLOGY	0.252323	22,317	5,631 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.857042	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.458194	19,699	9,026 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.413481	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.438812	163,821	71,887 73.00
76.00	03020 ONCOLOGY	0.544415	0	0 76.00
76.97	07697 CARDIAC REHABILITATION	0.954894	136	130 76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.456606	178	81 90.00
91.00	09100 EMERGENCY	0.268724	5,586	1,501 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.786663	0	0 92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,856,310	616,380 200.00
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)		1,856,310	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150001	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/27/2014 6:07 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		963,155	30.00
31.00	03100	INTENSIVE CARE UNIT		124,065	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		177,888	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.267057	265,752	50.00
53.00	05300	ANESTHESIOLOGY	0.055105	41,316	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180227	143,547	54.00
60.00	06000	LABORATORY	0.211596	387,035	60.00
65.00	06500	RESPIRATORY THERAPY	0.317925	159,587	65.00
66.00	06600	PHYSICAL THERAPY	0.492843	7,284	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.220504	7,556	67.00
68.00	06800	SPEECH PATHOLOGY	0.391947	2,360	68.00
69.00	06900	ELECTROCARDIOLOGY	0.252323	52,201	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.857042	350	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.458194	100,238	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.413481	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.438812	278,072	73.00
76.00	03020	ONCOLOGY	0.544415	2,892	76.00
76.97	07697	CARDIAC REHABILITATION	0.954894	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.456606	321	90.00
91.00	09100	EMERGENCY	0.268724	105,358	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.786663	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,553,869	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		1,553,869	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150001 Component CCN: 15T001	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/27/2014 6:07 pm	
		Title XIX	Subprovider - IRF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
41.00	04100 SUBPROVIDER - IRF		63,437		41.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.267057	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.055105	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.180227	423	76	54.00
60.00	06000 LABORATORY	0.211596	13,685	2,896	60.00
65.00	06500 RESPIRATORY THERAPY	0.317925	8,287	2,635	65.00
66.00	06600 PHYSICAL THERAPY	0.492843	21,538	10,615	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.220504	22,884	5,046	67.00
68.00	06800 SPEECH PATHOLOGY	0.391947	9,835	3,855	68.00
69.00	06900 ELECTROCARDIOLOGY	0.252323	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.857042	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.458194	202	93	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.413481	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.438812	6,478	2,843	73.00
76.00	03020 ONCOLOGY	0.544415	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.954894	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.456606	0	0	90.00
91.00	09100 EMERGENCY	0.268724	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.786663	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		83,332	28,059	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)		83,332		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150001	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/27/2014 6:07 pm
		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)		4,419,268	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		1,207,909	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)		8,349	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)		82.58	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.94	30.00
31.00	Percentage of Medicaid patient days (see instructions)		13.40	31.00
32.00	Sum of lines 30 and 31		17.34	32.00
33.00	Allowable disproportionate share percentage (see instructions)		4.02	33.00
34.00	Disproportionate share adjustment (see instructions)		189,794	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150001	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/27/2014 6:07 pm	
		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)			0.000061598	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			557,239	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			140,455	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		140,455		36.00
Additional payment for high percentage of ESRD beneficiary discharges					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)			0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)			0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)			0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41)			0	46.00
47.00	Subtotal (see instructions)		5,965,775		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)			0	48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		5,965,775		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		448,165		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)			0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)			0	56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).			0	57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		6,413,940		59.00
60.00	Primary payer payments		4,586		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		6,409,354		61.00
62.00	Deductibles billed to program beneficiaries		765,670		62.00
63.00	Coinurance billed to program beneficiaries		6,808		63.00
64.00	Allowable bad debts (see instructions)		92,879		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		60,371		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		46,375		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		5,697,247		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)			-5,047	70.93
70.94	Hospital readmissions reduction adjustment (see instructions)			0	70.94
70.95	Recovery of Accelerated Depreciation			0	70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150001	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/27/2014 6:07 pm	
		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)		5,692,200		71.00
71.01	Sequestration adjustment (see instructions)		85,952		71.01
72.00	Interim payments		5,740,796		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		-134,548		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		35,400		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: 150001

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/27/2014 6:07 pm

		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	4,419,268	0	0	0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013	1.02	1,207,909	0	4,419,268	1,207,909	5,627,177	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	8,349	0	0	8,349	8,349	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	0.0402	0.0402	0.0402	0.0402		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	189,794	0	177,654	12,140	189,794	11.00
11.01	Uncompensated care payments	36.00	140,455	140,455	0	0	140,455	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	5,965,775	140,455	4,596,922	1,228,398	5,965,775	13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49.00	5,965,775	140,455	4,596,922	1,228,398	5,965,775	15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50.00	448,165	0	0	448,165	448,165	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			140,455	4,596,922	1,676,563	6,413,940	19.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150001

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/27/2014 6:07 pm

		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	447,491	0	0	447,491	447,491	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	674	0	0	674	674	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	448,165	0	0	448,165	448,165	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				0.061964	0.087500		27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.96			284,844		284,844	28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.97				146,699	146,699	29.00
100.00	Transfer low volume adjustments to W/S E Part A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150001	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/27/2014 6:07 pm
		Title XVII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		3,563	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		8,211,556	2.00
3.00	PPS payments		6,723,160	3.00
4.00	Outlier payment (see instructions)		61,999	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		3,563	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		12,713	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)		12,713	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)		12,713	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		9,150	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		3,563	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		6,785,159	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		11	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,506,983	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		5,281,728	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		5,281,728	30.00
31.00	Primary payer payments		2,058	31.00
32.00	Subtotal (line 30 minus line 31)		5,279,670	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)		244,399	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		158,859	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		150,034	36.00
37.00	Subtotal (see instructions)		5,438,529	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-7	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)		5,438,536	40.00
40.01	Sequestration adjustment (see instructions)		82,122	40.01
41.00	Interim payments		5,388,833	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-32,419	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150001 Component CCN: 15T001	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/27/2014 6:07 pm
		Title XVII I	Subprovider - IRF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			326 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			110 2.00
3.00	PPS payments			213 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			326 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			744 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)			744 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)			744 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			418 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)			326 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)			213 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)			0 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)			539 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)			539 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			539 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)			0 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			0 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 36.00
37.00	Subtotal (see instructions)			539 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)			539 40.00
40.01	Sequestration adjustment (see instructions)			8 40.01
41.00	Interim payments			531 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			0 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150001

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

Worksheet E-1
Part I
Date/Time Prepared:
5/27/2014 6:07 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		5,740,796		5,388,833	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5,740,796		5,388,833	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		134,548		32,419	6.02	
7.00	Total Medicare program liability (see instructions)		5,606,248		5,356,414	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: 150001
Component CCN: 15T001

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

Worksheet E-1
Part I
Date/Time Prepared:
5/27/2014 6:07 pm
PPS

Title XVIII

Subprovider -
IRF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,712,777		531	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,712,777		531	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		37,742		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,750,519		531	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: 150001

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

Worksheet E-1
Part II
Date/Time Prepared:
5/27/2014 6:07 pm

Title XVIII		Hospital	PPS
			1.00

TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS			
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	2,242	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	3,665	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2	1,047	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	7,699	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	168,304,414	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	5,854,368	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)	1,055,111	8.00
9.00	Sequestration adjustment amount (see instructions)	21,102	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1,034,009	10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30.00	Initial/interim HIT payment adjustment (see instructions)	1,069,548	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)	-35,539	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150001 Component CCN: 15T001	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part III Date/Time Prepared: 5/27/2014 6:07 pm
		Title XVIIII	Subprovider - IRF	PPS
		Prior to 10/01	On/After 10/01	
		1.00	1.01	
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)	1,338,830	349,769	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0000		2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	79,259	14,131	3.00
4.00	Outlier Payments	20,768		4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00		5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00		5.01
6.00	New Teaching program adjustment. (see instructions)	0.00		6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program". (see inst.)	0.00		7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program". (see inst.)	0.00		8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00		9.00
10.00	Average Daily Census (see instructions)	5.326027		10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	0	12.00
13.00	Total PPS Payment (see instructions)	1,802,757		13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0		14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			15.00
16.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0		16.00
17.00	Subtotal (see instructions)	1,802,757		17.00
18.00	Primary payer payments	0		18.00
19.00	Subtotal (line 17 less line 18).	1,802,757		19.00
20.00	Deductibles	24,808		20.00
21.00	Subtotal (line 19 minus line 20)	1,777,949		21.00
22.00	Coinurance	592		22.00
23.00	Subtotal (line 21 minus line 22)	1,777,357		23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0		24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0		25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		26.00
27.00	Subtotal (sum of lines 23 and 25)	1,777,357		27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0		28.00
29.00	Other pass through costs (see instructions)	0		29.00
30.00	Outlier payments reconciliation	0		30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		31.00
31.99	Recovery of Accelerated Depreciation	0		31.99
32.00	Total amount payable to the provider (see instructions)	1,777,357		32.00
32.01	Sequestration adjustment (see instructions)	26,838		32.01
33.00	Interim payments	1,712,777		33.00
34.00	Tentative settlement (for contractor use only)	0		34.00
35.00	Balance due provider/program line 32 minus lines 32.01, 33 and 34	37,742		35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	11,600		36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4	20,768		50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0		51.00
52.00	The rate used to calculate the Time Value of Money	0.00		52.00
53.00	Time Value of Money (see instructions)	0		53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150001	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part VII Date/Time Prepared: 5/27/2014 6:07 pm
		Title XIX	Hospital	Cost
		Inpatient	Outpatient	
		1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	948,782		1.00
2.00	Medical and other services		1,100,329	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	948,782	1,100,329	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	948,782	1,100,329	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	1,553,869	4,235,634	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,553,869	4,235,634	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,553,869	4,235,634	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	605,087	3,135,305	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	948,782	1,100,329	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	948,782	1,100,329	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	948,782	1,100,329	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	948,782	1,100,329	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	948,782	1,100,329	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	948,782	1,100,329	40.00
41.00	Interim payments	948,782	1,100,329	41.00
42.00	Balance due provider/program (line 40 minus 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150001 Component CCN: 15T001	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part VII Date/Time Prepared: 5/27/2014 6:07 pm
		Title XIX	Subprovider - IRF	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	295,522		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	295,522	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	295,522	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	83,332	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	83,332	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	83,332	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	212,190	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	83,332	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	83,332	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	212,190	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	83,332	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	83,332	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	83,332	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	83,332	0	40.00
41.00	Interim payments	83,332	0	41.00
42.00	Balance due provider/program (line 40 minus 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	0	43.00

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

Provider CCN: 150001

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

Worksheet G

Date/Time Prepared:
5/27/2014 6:07 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	4,421,768	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	14,610,405	0	0	0	4.00
5.00	Other receivable	3,816,282	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,274,797	0	0	0	6.00
7.00	Inventory	1,653,162	0	0	0	7.00
8.00	Prepaid expenses	1,577,412	0	0	0	8.00
9.00	Other current assets	3,476,689	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)	25,280,921	0	0	0	11.00
FIXED ASSETS						
12.00	Land	3,141,963	0	0	0	12.00
13.00	Land improvements	1,604,444	0	0	0	13.00
14.00	Accumulated depreciation	-995,130	0	0	0	14.00
15.00	Buildings	65,122,650	0	0	0	15.00
16.00	Accumulated depreciation	-34,420,541	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	11,410,038	0	0	0	19.00
20.00	Accumulated depreciation	-9,185,790	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	36,763,492	0	0	0	23.00
24.00	Accumulated depreciation	-27,611,930	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	480,766	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	46,309,962	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	32,677,099	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,095,553	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	34,772,652	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	106,363,535	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,347,054	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	785,323	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,422,999	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,555,376	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	381,260	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)	381,260	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	6,936,636	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	99,426,899				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)	99,426,899	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	106,363,535	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150001

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

Worksheet G-1

Date/Time Prepared:
5/27/2014 6:07 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		87,807,398		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-856,636			2.00
3.00	Total (sum of line 1 and line 2)		86,950,762		0	3.00
4.00	TRANSFER FROM OTHER FUNDS	12,476,137		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)		12,476,137		0	10.00
11.00	Subtotal (line 3 plus line 10)		99,426,899		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		99,426,899		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	TRANSFER FROM OTHER FUNDS		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150001

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/27/2014 6:07 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	12,546,436		12,546,436	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	2,171,287		2,171,287	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	14,717,723		14,717,723	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	2,259,659		2,259,659	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)	2,259,659		2,259,659	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	16,977,382		16,977,382	17.00
18.00	Ancillary services	33,147,059	97,504,794	130,651,853	18.00
19.00	Outpatient services	0	19,721,971	19,721,971	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		1,538,922	1,538,922	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	PHYSICIANS	0	8,438,454	8,438,454	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	50,124,441	127,204,141	177,328,582	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		77,577,239		29.00
30.00	LOSS ON SALE OF ASSETS	22,726			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)		22,726		36.00
37.00	FISCAL SERVICES EXPENSES	310,499			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)		310,499		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		77,289,466		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150001

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

Worksheet G-3

Date/Time Prepared:
5/27/2014 6:07 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	177,328,582	1.00
2.00	Less contractual allowances and discounts on patients' accounts	105,045,268	2.00
3.00	Net patient revenues (line 1 minus line 2)	72,283,314	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	77,289,466	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-5,006,152	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,165,033	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	2,306,188	24.00
24.01	OTHER NON-OPERATING REVENUE	98,983	24.01
24.02	RENTAL INCOME	579,312	24.02
25.00	Total other income (sum of lines 6-24)	4,149,516	25.00
26.00	Total (line 5 plus line 25)	-856,636	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)	-856,636	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 150001

Period: From 01/01/2013

Worksheet H

HHA CCN: 157510

To 12/31/2013

Date/Time Prepared: 5/27/2014 6:07 pm

Home Health Agency I

PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	181,633	0	66,963	0	177,305	425,901	5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	288,949	0	0	0	0	288,949	6.00
7.00	Physical Therapy	114,311	0	0	0	0	114,311	7.00
8.00	Occupational Therapy	76,450	0	0	0	0	76,450	8.00
9.00	Speech Pathology	2,290	0	0	0	0	2,290	9.00
10.00	Medical Social Services	102	0	0	0	0	102	10.00
11.00	Home Health Aide	25,584	0	0	0	0	25,584	11.00
12.00	Supplies (see instructions)	0	0	0	0	10,850	10,850	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	689,319	0	66,963	0	188,155	944,437	24.00
		Reclassifi cation	Reclassifi ed Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	425,901	-965	424,936			5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	0	288,949	0	288,949			6.00
7.00	Physical Therapy	0	114,311	0	114,311			7.00
8.00	Occupational Therapy	0	76,450	0	76,450			8.00
9.00	Speech Pathology	0	2,290	0	2,290			9.00
10.00	Medical Social Services	0	102	0	102			10.00
11.00	Home Health Aide	0	25,584	0	25,584			11.00
12.00	Supplies (see instructions)	0	10,850	0	10,850			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	0	944,437	-965	943,472			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 150001	Period: From 01/01/2013	Worksheet H-1
		HHA CCN: 157510	To 12/31/2013	Part I
				Date/Time Prepared: 5/27/2014 6:07 pm
			Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)		
		Bldgs & Fixtures	Movable Equipment					
		1.00	2.00					3.00
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00	
2.00	Capital Related - Movable Equipment	0	0			0	2.00	
3.00	Plant Operation & Maintenance	0	0	0		0	3.00	
4.00	Transportation	0	0	0	0	0	4.00	
5.00	Administrative and General	424,936	0	0	0	424,936	5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	288,949	0	0	0	288,949	6.00	
7.00	Physical Therapy	114,311	0	0	0	114,311	7.00	
8.00	Occupational Therapy	76,450	0	0	0	76,450	8.00	
9.00	Speech Pathology	2,290	0	0	0	2,290	9.00	
10.00	Medical Social Services	102	0	0	0	102	10.00	
11.00	Home Health Aide	25,584	0	0	0	25,584	11.00	
12.00	Supplies (see instructions)	10,850	0	0	0	10,850	12.00	
13.00	Drugs	0	0	0	0	0	13.00	
14.00	DME	0	0	0	0	0	14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	23.00	
24.00	Total (sum of lines 1-23)	943,472	0	0	0	943,472	24.00	
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures						1.00	
2.00	Capital Related - Movable Equipment						2.00	
3.00	Plant Operation & Maintenance						3.00	
4.00	Transportation						4.00	
5.00	Administrative and General	424,936					5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	236,791	525,740				6.00	
7.00	Physical Therapy	93,677	207,988				7.00	
8.00	Occupational Therapy	62,650	139,100				8.00	
9.00	Speech Pathology	1,877	4,167				9.00	
10.00	Medical Social Services	84	186				10.00	
11.00	Home Health Aide	20,966	46,550				11.00	
12.00	Supplies (see instructions)	8,891	19,741				12.00	
13.00	Drugs	0	0				13.00	
14.00	DME	0	0				14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0				15.00	
16.00	Respiratory Therapy	0	0				16.00	
17.00	Private Duty Nursing	0	0				17.00	
18.00	Clinic	0	0				18.00	
19.00	Health Promotion Activities	0	0				19.00	
20.00	Day Care Program	0	0				20.00	
21.00	Home Delivered Meals Program	0	0				21.00	
22.00	Homemaker Service	0	0				22.00	
23.00	All Others (specify)	0	0				23.00	
24.00	Total (sum of lines 1-23)		943,472				24.00	

COST ALLOCATION - HHA STATISTICAL BASIS		Provider CCN: 150001 HHA CCN: 157510	Period: From 01/01/2013 To 12/31/2013	Worksheet H-1 Part II Date/Time Prepared: 5/27/2014 6:07 pm
			Home Health Agency I	PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-424,936	518,536
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	288,949
7.00	Physical Therapy	0	0	0	0	0	114,311
8.00	Occupational Therapy	0	0	0	0	0	76,450
9.00	Speech Pathology	0	0	0	0	0	2,290
10.00	Medical Social Services	0	0	0	0	0	102
11.00	Home Health Aide	0	0	0	0	0	25,584
12.00	Supplies (see instructions)	0	0	0	0	0	10,850
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-424,936	518,536
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		424,936
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.819492

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150001

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

Worksheet H-2 Part I

HHA CCN: 157510

Home Health Agency I

Date/Time Prepared: 5/27/2014 6:07 pm

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
		BLDG & FIXT	BLDG & FIXT - TOWER	MVBLE EQUIP			
		1.00	1.01	2.00			
	0	14,687	0	872	43,126	8,373	1.00
1.00 Administrative and General	0	14,687	0	872	43,126	8,373	1.00
2.00 Skilled Nursing Care	525,740	0	0	0	68,607	0	2.00
3.00 Physical Therapy	207,988	0	0	0	27,142	0	3.00
4.00 Occupational Therapy	139,100	0	0	0	18,152	0	4.00
5.00 Speech Pathology	4,167	0	0	0	544	0	5.00
6.00 Medical Social Services	186	0	0	0	24	0	6.00
7.00 Home Health Aide	46,550	0	0	0	6,075	0	7.00
8.00 Supplies (see instructions)	19,741	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	943,472	14,687	0	872	163,670	8,373	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description	DATA PROCESSING	MATERIALS MANAGEMENT	ADMITTING	PATIENT ACCOUNTING	Subtotal	ADMINISTRATIVE & GENERAL	
	4.02	4.03	4.04	4.05	4A.05	5.00	
1.00 Administrative and General	62,296	1,406	8,967	18,775	158,502	18,000	1.00
2.00 Skilled Nursing Care	0	0	0	0	594,347	67,493	2.00
3.00 Physical Therapy	0	0	0	0	235,130	26,702	3.00
4.00 Occupational Therapy	0	0	0	0	157,252	17,858	4.00
5.00 Speech Pathology	0	0	0	0	4,711	535	5.00
6.00 Medical Social Services	0	0	0	0	210	24	6.00
7.00 Home Health Aide	0	0	0	0	52,625	5,976	7.00
8.00 Supplies (see instructions)	0	0	0	0	19,741	2,242	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	62,296	1,406	8,967	18,775	1,222,518	138,830	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150001

Period: From 01/01/2013

Worksheet H-2

HHA CCN: 157510

To 12/31/2013

Part I
Date/Time Prepared:
5/27/2014 6:07 pm

Home Health Agency I

PPS

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	31,529	0	11,267	0	16,916	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	31,529	0	11,267	0	16,916	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	12,201	248,415	0	248,415	1.00
2.00	Skilled Nursing Care	0	0	0	661,840	0	661,840	2.00
3.00	Physical Therapy	0	0	0	261,832	0	261,832	3.00
4.00	Occupational Therapy	0	0	0	175,110	0	175,110	4.00
5.00	Speech Pathology	0	0	0	5,246	0	5,246	5.00
6.00	Medical Social Services	0	0	0	234	0	234	6.00
7.00	Home Health Aide	0	0	0	58,601	0	58,601	7.00
8.00	Supplies (see instructions)	0	0	0	21,983	0	21,983	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	12,201	1,433,261	0	1,433,261	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150001

Period:

Worksheet H-2

HHA CCN: 157510

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

Part I
Date/Time Prepared:
5/27/2014 6:07 pm

Home Health
Agency I

PPS

Cost Center Description		Allocated HHA A&G (see Part II)	Total HHA Costs		
		27.00	28.00		
1.00	Administrative and General				1.00
2.00	Skilled Nursing Care	138,761	800,601		2.00
3.00	Physical Therapy	54,896	316,728		3.00
4.00	Occupational Therapy	36,714	211,824		4.00
5.00	Speech Pathology	1,100	6,346		5.00
6.00	Medical Social Services	49	283		6.00
7.00	Home Health Aide	12,286	70,887		7.00
8.00	Supplies (see instructions)	4,609	26,592		8.00
9.00	Drugs	0	0		9.00
10.00	DME	0	0		10.00
11.00	Home Dialysis Aide Services	0	0		11.00
12.00	Respiratory Therapy	0	0		12.00
13.00	Private Duty Nursing	0	0		13.00
14.00	Clinic	0	0		14.00
15.00	Health Promotion Activities	0	0		15.00
16.00	Day Care Program	0	0		16.00
17.00	Home Delivered Meals Program	0	0		17.00
18.00	Homemaker Service	0	0		18.00
19.00	All Others (specify)	0	0		19.00
20.00	Total (sum of lines 1-19) (2)	248,415	1,433,261		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.209660			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150001
HHA CCN: 157510

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

Worksheet H-2
Part II
Date/Time Prepared: 5/27/2014 6:07 pm
PPS

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (# NON PT PHONES)	DATA PROCESSING (WORK ORDERS)	
		BLDG & FIXT (TOTAL FEET)	BLDG & FIXT - TOWER (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	1.01	2.00				
1.00	Administrative and General	2,228	0	868	181,633	21	67	1.00
2.00	Skilled Nursing Care	0	0	0	288,949	0	0	2.00
3.00	Physical Therapy	0	0	0	114,311	0	0	3.00
4.00	Occupational Therapy	0	0	0	76,450	0	0	4.00
5.00	Speech Pathology	0	0	0	2,290	0	0	5.00
6.00	Medical Social Services	0	0	0	102	0	0	6.00
7.00	Home Health Aide	0	0	0	25,584	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	2,228	0	868	689,319	21	67	20.00
21.00	Total cost to be allocated	14,687	0	872	163,670	8,373	62,296	21.00
22.00	Unit cost multiplier	6.592011	0.000000	1.004608	0.237437	398.714286	929.791045	22.00
Cost Center Description		MATERIALS MANAGEMENT (SUPPLY USAGE)	ADMINISTERING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (TOTAL FEET)	
		4.03	4.04	4.05	5A	5.00	7.00	
1.00	Administrative and General	18,880	1,538,922	1,538,922	0	158,502	2,228	1.00
2.00	Skilled Nursing Care	0	0	0	0	594,347	0	2.00
3.00	Physical Therapy	0	0	0	0	235,130	0	3.00
4.00	Occupational Therapy	0	0	0	0	157,252	0	4.00
5.00	Speech Pathology	0	0	0	0	4,711	0	5.00
6.00	Medical Social Services	0	0	0	0	210	0	6.00
7.00	Home Health Aide	0	0	0	0	52,625	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	19,741	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	18,880	1,538,922	1,538,922	0	1,222,518	2,228	20.00
21.00	Total cost to be allocated	1,406	8,967	18,775	0	138,830	31,529	21.00
22.00	Unit cost multiplier	0.074470	0.005827	0.012200	0	0.113561	14.151257	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150001

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

Worksheet H-2 Part II Date/Time Prepared: 5/27/2014 6:07 pm

		Home Health Agency I					PPS	
Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (TOTAL FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS PAID)	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	2,228	0	23,727	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	2,228	0	23,727	0	0	20.00
21.00	Total cost to be allocated	0	11,267	0	16,916	0	0	21.00
22.00	Unit cost multiplier	0.000000	5.057002	0.000000	0.712943	0.000000	0.000000	22.00
Cost Center Description		PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)					
		15.00	16.00					
1.00	Administrative and General	0	1,538,922					1.00
2.00	Skilled Nursing Care	0	0					2.00
3.00	Physical Therapy	0	0					3.00
4.00	Occupational Therapy	0	0					4.00
5.00	Speech Pathology	0	0					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	0	0					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
20.00	Total (sum of lines 1-19)	0	1,538,922					20.00
21.00	Total cost to be allocated	0	12,201					21.00
22.00	Unit cost multiplier	0.000000	0.007928					22.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 150001 HHA CCN: 157510	Period: From 01/01/2013 To 12/31/2013	Worksheet H-3 Part I Date/Time Prepared: 5/27/2014 6:07 pm		
				Title XVIII	Home Health Agency I	PPS		
Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)		
	0	1.00	2.00	3.00	4.00	5.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	800,601		800,601	2,502	319.98	1.00
2.00	Physical Therapy	3.00	316,728	0	316,728	1,472	215.17	2.00
3.00	Occupational Therapy	4.00	211,824	0	211,824	695	304.78	3.00
4.00	Speech Pathology	5.00	6,346	0	6,346	23	275.91	4.00
5.00	Medical Social Services	6.00	283		283	4	70.75	5.00
6.00	Home Health Aide	7.00	70,887		70,887	439	161.47	6.00
7.00	Total (sum of lines 1-6)		1,406,669	0	1,406,669	5,135		7.00
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles								
0	1.00	2.00	3.00	4.00	5.00			
Limitation Cost Computation								
8.00	Skilled Nursing Care	18020	107	105			8.00	
8.01	Skilled Nursing Care	26900	656	863			8.01	
9.00	Physical Therapy	18020	78	65			9.00	
9.01	Physical Therapy	26900	359	578			9.01	
10.00	Occupational Therapy	18020	50	38			10.00	
10.01	Occupational Therapy	26900	258	439			10.01	
11.00	Speech Pathology	18020	0	0			11.00	
11.01	Speech Pathology	26900	11	11			11.01	
12.00	Medical Social Services	18020	0	0			12.00	
12.01	Medical Social Services	26900	2	1			12.01	
13.00	Home Health Aide	18020	4	24			13.00	
13.01	Home Health Aide	26900	98	285			13.01	
14.00	Total (sum of lines 8-13)		1,623	2,409			14.00	
Cost Center Description								
From Wkst. H-2 Part I, col. 28, line								
Facility Costs (from Wkst. H-2, Part I)								
Shared Ancillary Costs (from Part II)								
Total HHA Costs (cols. 1 + 2)								
Total Charges (From HHA Record)								
Ratio (col. 3 ÷ col. 4)								
0	1.00	2.00	3.00	4.00	5.00			
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	26,592	0	26,592	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00
Program Visits								
Cost of Services								
Part B								
Part A								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles & Coinsurance								
6.00	7.00	8.00	9.00	10.00	11.00			
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	763	968	244,145	309,741		1.00	
2.00	Physical Therapy	437	643	94,029	138,354		2.00	
3.00	Occupational Therapy	308	477	93,872	145,380		3.00	
4.00	Speech Pathology	11	11	3,035	3,035		4.00	
5.00	Medical Social Services	2	1	142	71		5.00	
6.00	Home Health Aide	102	309	16,470	49,894		6.00	
7.00	Total (sum of lines 1-6)	1,623	2,409	451,693	646,475		7.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150001

Period: From 01/01/2013

Worksheet H-3

HHA CCN: 157510

To 12/31/2013

Part I
Date/Time Prepared:
5/27/2014 6:07 pm

Title XVII I

Home Health Agency I

PPS

Cost Center Description		6.00	7.00	8.00	9.00	10.00	11.00		
Limitation Cost Computation									
8.00	Skilled Nursing Care							8.00	
8.01	Skilled Nursing Care							8.01	
9.00	Physical Therapy							9.00	
9.01	Physical Therapy							9.01	
10.00	Occupational Therapy							10.00	
10.01	Occupational Therapy							10.01	
11.00	Speech Pathology							11.00	
11.01	Speech Pathology							11.01	
12.00	Medical Social Services							12.00	
12.01	Medical Social Services							12.01	
13.00	Home Health Aide							13.00	
13.01	Home Health Aide							13.01	
14.00	Total (sum of lines 8-13)							14.00	
Cost Center Description		Program Covered Charges			Cost of Services				
		Part A	Part B		Part A	Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
		6.00	7.00	8.00	9.00	10.00	11.00		
Supplies and Drugs Cost Computations									
15.00	Cost of Medical Supplies							15.00	
16.00	Cost of Drugs		0	0		0	0	16.00	
Cost Center Description		Total Program Cost (sum of col.s. 9-10)							
		12.00							
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	553,886							1.00
2.00	Physical Therapy	232,383							2.00
3.00	Occupational Therapy	239,252							3.00
4.00	Speech Pathology	6,070							4.00
5.00	Medical Social Services	213							5.00
6.00	Home Health Aide	66,364							6.00
7.00	Total (sum of lines 1-6)	1,098,168							7.00
Cost Center Description									
		12.00							
Limitation Cost Computation									
8.00	Skilled Nursing Care							8.00	
8.01	Skilled Nursing Care							8.01	
9.00	Physical Therapy							9.00	
9.01	Physical Therapy							9.01	
10.00	Occupational Therapy							10.00	
10.01	Occupational Therapy							10.01	
11.00	Speech Pathology							11.00	
11.01	Speech Pathology							11.01	
12.00	Medical Social Services							12.00	
12.01	Medical Social Services							12.01	
13.00	Home Health Aide							13.00	
13.01	Home Health Aide							13.01	
14.00	Total (sum of lines 8-13)							14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 150001 HHA CCN: 157510	Period: From 01/01/2013 To 12/31/2013	Worksheet H-3 Part II Date/Time Prepared: 5/27/2014 6:07 pm
			Title XVIII	Home Health Agency I

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
	0	1.00	2.00	3.00	4.00	
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.492843	0	0	col. 2, line 2.00 1.00
2.00	Occupational Therapy	67.00	0.220504	0	0	col. 2, line 3.00 2.00
3.00	Speech Pathology	68.00	0.391947	0	0	col. 2, line 4.00 3.00
4.00	Cost of Medical Supplies	71.00	0.458194	0	0	col. 2, line 15.00 4.00
5.00	Cost of Drugs	73.00	0.438812	0	0	col. 2, line 16.00 5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 150001 HHA CCN: 157510	Period: From 01/01/2013 To 12/31/2013	Worksheet H-4 Part I-II Date/Time Prepared: 5/27/2014 6:07 pm
		Title XVII I	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount 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(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		275,292	416,396
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	0
13.00	Total PPS Reimbursement - LUPA Episodes		5,131	3,358
14.00	Total PPS Reimbursement - PEP Episodes		4,206	7,559
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	0
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	5
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		284,629	427,318
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		284,629	427,318
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		284,629	427,318
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		284,629	427,318
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		284,629	427,318
31.01	Sequestration adjustment (see instructions)		3,599	6,610
32.00	Interim payments (see instructions)		281,030	420,708
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	0

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 150001
HHA CCN: 157510

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

Worksheet H-5
Date/Time Prepared:
5/27/2014 6:07 pm
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		281,030		420,708	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			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			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. H-4, Part II, column as appropriate, line 32)		281,030		420,708	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		281,030		420,708	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150001	Period: From 01/01/2013 To 12/31/2013	Worksheet L Parts I-III Date/Time Prepared: 5/27/2014 6:07 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		447,491	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		674	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)		21.09	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)		448,165	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