

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: 150072  
 Period: From 01/01/2013 To 12/31/2013  
 Worksheet 5 Parts I-III  
 Date/Time Prepared: 5/27/2014 5:44 pm

**PART I - COST REPORT STATUS**

Provider use only  
 1.  Electronically filed cost report  
 2.  Manually submitted cost report  
 3.  If this is an amended report enter the number of times the provider resubmitted this cost report  
 4.  Medicare Utilization. Enter "F" for full or "L" for low.

Date: 5/27/2014 Time: 5:44 pm

Contractor use only  
 5.  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.  Initial Report for this Provider CCN  
 9.  Final Report for this Provider CCN  
 10. NPR Date:  
 11. Contractor's Vendor Code: 4  
 12.  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 MEMORIAL HOSPITAL LOGANSPOORT ( 150072 ) for the cost reporting period beginning 01/01/2013 and ending 12/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

**Encryption Information**

ECR: Date: 5/27/2014 Time: 5:44 pm  
 t06Bowlq8ECQcgT6zikp: idORbxSJO  
 MQk6K0Hip6SikEXxsh1o.qm2ZPYM4g  
 ;kHC0j2bdh001Afr  
 PI: Date: 5/27/2014 Time: 5:44 pm  
 ExLrjgHSzMOZwtryKb.kIA81XVwjLO  
 YXBhl08jffj5lCewQxFZM16o0fuvJby  
 Sbut0:Q0JI0BD4jb

(Signed)

*Julia R Berndt*

Officer or Administrator of Provider(s)

CFO

Title

5.30.14

Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	-49,126	30,557	-14,995	-31,466	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00 Total	0	-49,126	30,557	-14,995	-31,466	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: 150072		Period: From 01/01/2013 To 12/31/2013		Worksheet S-2 Part I Date/Time Prepared: 5/27/2014 5:30 pm					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1101 MICHIGAN AVENUE		PO Box:						1.00		
2.00	City: LOGANSPO RT		State: IN		Zip Code: 46947-		County: CASS		2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		MEMORIAL HOSPITAL LOGANSPO RT	150072	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF		SWING BED - SNF	15U072	99915		05/14/2008	N	P	P	7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
17.10	Hospital-Based (CORF) I										17.10
18.00	Renal Dialysis										18.00
19.00	Other										19.00
						From:	To:				
						1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2013		12/31/2013		20.00	
21.00	Type of Control (see instructions)							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		Y		22.01	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3		N		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days				
		1.00	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.	589	0	0	0	989	0		24.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0		25.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150072	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/27/2014 5:30 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.	2			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	1			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.	01/01/2013	12/31/2013		36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	Y		39.00	
		V	XVII	XIX		
		1.00	2.00	3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	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	
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150072		Period: From 01/01/2013 To 12/31/2013		Worksheet S-2 Part I Date/Time Prepared: 5/27/2014 5:30 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 67.00	
				1.00	2.00	3.00	
<b>Inpatient Psychiatric Facility PPS</b>							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	76.00
				1.00			
<b>Long Term Care Hospital PPS</b>							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00	
<b>TEFRA Providers</b>							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00	
				V	XIX		
				1.00	2.00		
<b>Title V and XIX Services</b>							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00		95.00

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		V	XIX			
		1.00	2.00			
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column. Rural Providers	0.00	0.00		97.00	
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N			105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	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.	1			118.00	
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	692,330	0	0		118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02	
119.00	DO NOT USE THIS LINE				119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	Y		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00	
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150072		Period: From 01/01/2013 To 12/31/2013		Worksheet S-2 Part I Date/Time Prepared: 5/27/2014 5:30 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		2.00		3.00							
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00							
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.			N		145.00							
		1.00		2.00									
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.			N		146.00							
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00							
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00							
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00							
		Part A		Part B		Title V		Title XIX					
		1.00		2.00		3.00		4.00					
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)													
155.00	Hospital		N		N		N		155.00				
156.00	Subprovider - IPF		N		N		N		156.00				
157.00	Subprovider - IRF		N		N		N		157.00				
158.00	SUBPROVIDER								158.00				
159.00	SNF		N		N		N		159.00				
160.00	HOME HEALTH AGENCY		N		N		N		160.00				
161.00	CMHC								161.00				
161.10	CORF				N		N		161.10				
		1.00		2.00		3.00		4.00					
Multi campus													
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00							
		Name		County		State		Zip Code		CBSA		FTE/Campus	
		0		1.00		2.00		3.00		4.00		5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5											0.00	
		1.00		2.00		3.00		4.00		5.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act													
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00							
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			0		168.00							
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.75		169.00							
		Beginning		Ending									
		1.00		2.00									
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			10/01/2012		09/30/2013		170.00					

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150072	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/27/2014 5:30 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
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	04/28/2014	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	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/13/2014	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: 150072	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/27/2014 5:30 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.	0	1.00 2.00	3.00 N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
			Y/N 1.00	Date 2.00	
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?			N	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.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
			1.00	2.00	
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MI CHAEL		ALESSANDRI NI	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7959		MALESSANDRI NI@BLUEANDCO.COM	43.00

		Part B		
		Date		
		4.00		
<b>PS&amp;R Data</b>				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	05/13/2014		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150072

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/27/2014 5:30 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	77	28,105	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)		77	28,105	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)		83	30,295	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		83				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: 150072

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/27/2014 5:30 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)	2,462	422	4,905			1.00
2.00 HMO and other (see instructions)	365	989				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	2,462	422	4,905			7.00
8.00 INTENSIVE CARE UNIT	392	0	603			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		167	963			13.00
14.00 Total (see instructions)	2,854	589	6,471	0.00	471.43	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	471.43	27.00
28.00 Observation Bed Days		237	1,529			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150072

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/27/2014 5:30 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	728	237	1,715	1.00
2.00 HMO and other (see instructions)			95			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	728	237	1,715	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00 SUBPROVIDER	0.00	0	0	0	0	18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00					25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150072

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/27/2014 5:30 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	26,356,913	0	26,356,913	980,603.00	26.88
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		1,502,521	0	1,502,521	10,342.00	145.28
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)		7,691,953	0	7,691,953	167,159.00	46.02
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract labor (see instructions)		499,064	0	499,064	9,627.00	51.84
12.00	Contract management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		165,397	0	165,397	2,151.00	76.89
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		5,976,762	0	5,976,762		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		1,228,510	0	1,228,510		
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		1,509	0	1,509		
24.00	Wage-related costs (RHC/FOHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits Department	4.00	233,944	0	233,944	8,320.00	28.12
27.00	Administrative & General	5.00	2,805,836	0	2,805,836	121,453.00	23.10
28.00	Administrative & General under contract (see inst.)		207,493	0	207,493	861.00	240.99
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	457,305	0	457,305	19,514.00	23.43
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00
32.00	Housekeeping	9.00	495,866	0	495,866	42,508.00	11.67
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	664,234	-469,118	195,116	17,213.00	11.34
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	469,118	469,118	41,519.00	11.30
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	443,241	0	443,241	11,767.00	37.67
39.00	Central Services and Supply	14.00	162,314	0	162,314	10,537.00	15.40
40.00	Pharmacy	15.00	405,844	0	405,844	22,739.00	17.85
41.00	Medical Records & Medical Records Library	16.00	481,759	0	481,759	28,370.00	16.98

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150072

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/27/2014 5:30 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	
42.00	Soci al Servi ce	17.00	220,896	0	220,896	9,235.00	23.92	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: 150072

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/27/2014 5:30 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	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	25,061,885	0	25,061,885	971,122.00	25.81	1.00
2.00	Excluded area salaries (see instructions)	7,691,953	0	7,691,953	167,159.00	46.02	2.00
3.00	Subtotal salaries (line 1 minus line 2)	17,369,932	0	17,369,932	803,963.00	21.61	3.00
4.00	Subtotal other wages & related costs (see inst.)	664,461	0	664,461	11,778.00	56.42	4.00
5.00	Subtotal wage-related costs (see inst.)	5,976,762	0	5,976,762	0.00	34.41	5.00
6.00	Total (sum of lines 3 thru 5)	24,011,155	0	24,011,155	815,741.00	29.43	6.00
7.00	Total overhead cost (see instructions)	6,578,732	0	6,578,732	334,036.00	19.69	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 150072

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

Worksheet S-3  
Part IV  
Date/Time Prepared:  
5/27/2014 5:30 pm

		Amount Reported	
		1.00	
<b>PART IV - WAGE RELATED COSTS</b>			
<b>Part A - Core List</b>			
<b>RETIREMENT COST</b>			
1.00	401K Employer Contributions	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)	764,886	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
5.00	401K/TSA Plan Administration Fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
<b>HEALTH AND INSURANCE COST</b>			
8.00	Health Insurance (Purchased or Self Funded)	3,956,161	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	133,285	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	33,562	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)	247,912	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	220,978	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	1,719,941	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	37,386	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
<b>OTHER</b>			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	70,934	23.00
24.00	<b>Total Wage Related cost (Sum of lines 1 -23)</b>	<b>7,185,045</b>	<b>24.00</b>
<b>Part B - Other than Core Related Cost</b>			
25.00	<b>OTHER WAGE RELATED COSTS</b>	<b>21,737</b>	<b>25.00</b>

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150072

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

Worksheet S-3  
Part V  
Date/Time Prepared:  
5/27/2014 5:30 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	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150072	Period: From 01/01/2013 To 12/31/2013	Worksheet S-10 Date/Time Prepared: 5/27/2014 5:30 pm
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			1.00		
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.287543	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		7,990,321	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		21,147,530	6.00	
7.00	Medicaid cost (line 1 times line 6)		6,080,824	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	
			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	3,013,036	0	3,013,036	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	866,377	0	866,377	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	866,377	0	866,377	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		7,109,466	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		148,067	27.00	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		6,961,399	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		2,001,702	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,868,079	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,868,079	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150072

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

Worksheet A  
Date/Time Prepared:  
5/27/2014 5:30 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		4,469,709	4,469,709	-443,035	4,026,674	1.00
1.01	00101		252,874	252,874	0	252,874	1.01
1.02	00102		147,484	147,484	0	147,484	1.02
4.00	00400	233,944	7,622,052	7,855,996	0	7,855,996	4.00
5.00	00500	2,805,836	4,939,550	7,745,386	692,330	8,437,716	5.00
7.00	00700	457,305	1,802,766	2,260,071	0	2,260,071	7.00
8.00	00800	0	192,787	192,787	0	192,787	8.00
9.00	00900	495,866	204,637	700,503	0	700,503	9.00
10.00	01000	664,234	312,311	976,545	-689,689	286,856	10.00
11.00	01100	0	0	0	689,689	689,689	11.00
13.00	01300	443,241	11,189	454,430	0	454,430	13.00
14.00	01400	162,314	1,950,486	2,112,800	-502,381	1,610,419	14.00
15.00	01500	405,844	1,225,552	1,631,396	0	1,631,396	15.00
16.00	01600	481,759	84,104	565,863	0	565,863	16.00
17.00	01700	220,896	26,782	247,678	0	247,678	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	2,569,276	259,997	2,829,273	-671,306	2,157,967	30.00
31.00	03100	505,460	34,834	540,294	0	540,294	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	11	11	239,031	239,042	43.00
44.00	04400	0	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	1,357,680	718,076	2,075,756	0	2,075,756	50.00
52.00	05200	67,881	1,555	69,436	432,275	501,711	52.00
53.00	05300	0	18,301	18,301	0	18,301	53.00
54.00	05400	967,306	876,384	1,843,690	0	1,843,690	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	960,841	1,512,436	2,473,277	0	2,473,277	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	45,643	171,956	217,599	0	217,599	63.00
65.00	06500	473,781	64,693	538,474	0	538,474	65.00
66.00	06600	38,727	465,168	503,895	0	503,895	66.00
69.00	06900	209,048	78,697	287,745	0	287,745	69.00
69.01	06901	81,635	5,514	87,149	0	87,149	69.01
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	502,381	502,381	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03020	187,450	232,974	420,424	0	420,424	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	3,376,742	582,360	3,959,102	0	3,959,102	90.00
91.00	09100	1,452,251	47,659	1,499,910	0	1,499,910	91.00
92.00	09200						92.00
93.00	04040	0	0	0	0	0	93.00
93.01	04041	0	0	0	0	0	93.01
93.02	04042	0	0	0	0	0	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	699	699	0	699	95.00
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		18,664,960	28,313,597	46,978,557	249,295	47,227,852	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07950	0	3,253	3,253	0	3,253	194.00
194.01	07951	0	4,692	4,692	0	4,692	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	648,012	220,564	868,576	0	868,576	194.04
194.05	07955	7,043,941	2,392,900	9,436,841	-249,295	9,187,546	194.05
194.06	07956	0	104	104	0	104	194.06
194.08	07958	0	0	0	0	0	194.08
200.00		26,356,913	30,935,110	57,292,023	0	57,292,023	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150072

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

Worksheet A  
Date/Time Prepared:  
5/27/2014 5:30 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-32,878	3,993,796	1.00
1.01	00101 MOB	0	252,874	1.01
1.02	00102 OPS	0	147,484	1.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-2,590	7,853,406	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-2,570,888	5,866,828	5.00
7.00	00700 OPERATION OF PLANT	-14,751	2,245,320	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	192,787	8.00
9.00	00900 HOUSEKEEPING	0	700,503	9.00
10.00	01000 DIETARY	-43,600	243,256	10.00
11.00	01100 CAFETERIA	-270,983	418,706	11.00
13.00	01300 NURSING ADMINISTRATION	0	454,430	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	1,610,419	14.00
15.00	01500 PHARMACY	0	1,631,396	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-23,396	542,467	16.00
17.00	01700 SOCIAL SERVICE	0	247,678	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS	0	2,157,967	30.00
31.00	03100 INTENSIVE CARE UNIT	0	540,294	31.00
41.00	04100 SUBPROVIDER - IIRF	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	42.00
43.00	04300 NURSERY	0	239,042	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	2,075,756	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	501,711	52.00
53.00	05300 ANESTHESIOLOGY	0	18,301	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	1,843,690	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	2,473,277	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	217,599	63.00
65.00	06500 RESPIRATORY THERAPY	-32,566	505,908	65.00
66.00	06600 PHYSICAL THERAPY	0	503,895	66.00
69.00	06900 ELECTROCARDIOLOGY	-31	287,714	69.00
69.01	06901 CARDIAC REHAB	0	87,149	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	502,381	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020 NUCLEAR MEDICINE-DIAGNOSTIC	0	420,424	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	-1,533,960	2,425,142	90.00
91.00	09100 EMERGENCY	0	1,499,910	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
93.01	04041 FAMILY PRACTICE	0	0	93.01
93.02	04042 FAMILY PRACTICE	0	0	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0	699	95.00
99.10	09910 CORF	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00	SUBTOTALS (SUM OF LINES 1-117)	-4,525,643	42,702,209	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
194.00	07950 FOUNDATION	0	3,253	194.00
194.01	07951 MOB	0	4,692	194.01
194.02	07952 OTHER NONREIMBURSABLE COST CENTERS	0	0	194.02
194.03	07953 PIH	0	0	194.03
194.04	07954 HEALTH COMPANIES	0	868,576	194.04
194.05	07955 PHYSICIANS OFFICE	0	9,187,546	194.05
194.06	07956 THE ARBORS	0	104	194.06
194.08	07958 OPS	0	0	194.08
200.00	TOTAL (SUM OF LINES 118-199)	-4,525,643	52,766,380	200.00

RECLASSIFICATIONS

Provider CCN: 150072

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

Worksheet A-6

Date/Time Prepared:  
5/27/2014 5:30 pm

		Increases			
		Cost Center	Line #	Salary	Other
		2.00	3.00	4.00	5.00
<b>A - CAFETERIA RECLASS</b>					
1.00	CAFETERIA		11.00	469,118	220,571
	TOTALS			469,118	220,571
<b>B - OB RECLASS</b>					
1.00	NURSERY		43.00	218,176	20,855
2.00	DELIVERY ROOM & LABOR ROOM		52.00	390,036	42,239
	TOTALS			608,212	63,094
<b>C - MALPRACTICE INS. RECLASS</b>					
1.00	ADMINISTRATIVE & GENERAL		5.00	0	692,330
2.00			0.00	0	0
	TOTALS			0	692,330
<b>D - IMPLANT EXPENSE RECLASS</b>					
1.00	IMPL. DEV. CHARGED TO		72.00	0	502,381
	PATIENT			0	502,381
	TOTALS			0	502,381
500.00	Grand Total: Increases			1,077,330	1,478,376

RECLASSIFICATIONS

Provider CCN: 150072

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

Worksheet A-6

Date/Time Prepared:  
5/27/2014 5:30 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	469,118	220,571	0	1.00
	TOTALS		469,118	220,571		
B - OB RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	608,212	63,094	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		608,212	63,094		
C - MALPRACTICE INS. RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FI XT	1.00	0	443,035	12	1.00
2.00	PHYSICIANS OFFICE	194.05	0	249,295	0	2.00
	TOTALS		0	692,330		
D - IMPLANT EXPENSE RECLASS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	502,381	0	1.00
	TOTALS		0	502,381		
500.00	Grand Total: Decreases		1,077,330	1,478,376		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150072

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/27/2014 5:30 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	205,783	0	0	0	0	1.00
2.00	Land Improvements	443,093	0	0	0	0	2.00
3.00	Buildings and Fixtures	57,294,583	565,246	0	565,246	8,662	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	30,823,479	3,907,985	0	3,907,985	406,002	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	88,766,938	4,473,231	0	4,473,231	414,664	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	88,766,938	4,473,231	0	4,473,231	414,664	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	205,783	0				1.00
2.00	Land Improvements	443,093	0				2.00
3.00	Buildings and Fixtures	57,851,167	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	34,325,462	0				5.00
6.00	Movable Equipment	0	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	92,825,505	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	92,825,505	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150072

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/27/2014 5:30 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	NEW CAP REL COSTS-BLDG & FIXT	3,463,178	0	444,341	562,190	0	1.00
1.01	MOB	252,874	0	0	0	0	1.01
1.02	OPS	147,484	0	0	0	0	1.02
3.00	Total (sum of lines 1-2)	3,863,536	0	444,341	562,190	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	4,469,709				1.00
1.01	MOB	0	252,874				1.01
1.02	OPS	0	147,484				1.02
3.00	Total (sum of lines 1-2)	0	4,870,067				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150072

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/27/2014 5:30 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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0 1.00
1.01	MOB	0	0	0	0.000000	0 1.01
1.02	OPS	0	0	0	0.000000	0 1.02
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0 3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
	Taxes	Other Capital-Related Costs	Total (sum of col s. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	3,431,624	0 1.00
1.01	MOB	0	0	0	252,874	0 1.01
1.02	OPS	0	0	0	147,484	0 1.02
3.00	Total (sum of lines 1-2)	0	0	0	3,831,982	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 s. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	444,341	117,831	0	0	3,993,796 1.00
1.01	MOB	0	0	0	0	252,874 1.01
1.02	OPS	0	0	0	0	147,484 1.02
3.00	Total (sum of lines 1-2)	444,341	117,831	0	0	4,394,154 3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7	Ref.
			1.00	2.00	3.00	4.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0NEW CAP REL COSTS-BLDG & FIXT	1.00		0 1.00
1.01 Investment income - MOB (chapter 2)			0MOB	1.01		0 1.01
1.02 Investment income - OPS (chapter 2)			0OPS	1.02		0 1.02
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0*** Cost Center Deleted ***	2.00		0 2.00
3.00 Investment income - other (chapter 2)			0	0.00		0 3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0	0.00		0 4.00
5.00 Refunds and rebates of expenses (chapter 8)			0	0.00		0 5.00
6.00 Rental of provider space by suppliers (chapter 8)			0	0.00		0 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0	0.00		0 7.00
8.00 Television and radio service (chapter 21)			0	0.00		0 8.00
9.00 Parking lot (chapter 21)			0	0.00		0 9.00
10.00 Provider-based physician adjustment	A-8-2	-1,566,557				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	A	-270,983	CAFETERIA	11.00		0 14.00
15.00 Rental of quarters to employee and others			0	0.00		0 15.00
16.00 Sale of medical and surgical supplies to other than patients			0	0.00		0 16.00
17.00 Sale of drugs to other than patients			0	0.00		0 17.00
18.00 Sale of medical records and abstracts			0	0.00		0 18.00
19.00 Nursing school (tuition, fees, books, etc.)			0	0.00		0 19.00
20.00 Vending machines			0	0.00		0 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0	0.00		0 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0	0.00		0 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0NEW CAP REL COSTS-BLDG & FIXT	1.00		0 26.00
26.01 Depreciation - MOB			0MOB	1.01		0 26.01
26.02 Depreciation - OPS			0OPS	1.02		0 26.02
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0*** Cost Center Deleted ***	2.00		0 27.00
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0	0.00		0 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99

Provider CCN: 150072

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

Worksheet A-8  
 Date/Time Prepared:  
 5/27/2014 5:30 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
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***		68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00
33.00 OTHER REVENUE - VENDING COMMISSION	B	-8,921	ADMINISTRATIVE & GENERAL		5.00	0	33.00
34.00 OTHER REVENUE - CASH OVER/SHORT	B	-13	ADMINISTRATIVE & GENERAL		5.00	0	34.00
35.00 OTHER REVENUE - MISCELLANEOUS	B	-9,989	ADMINISTRATIVE & GENERAL		5.00	0	35.00
36.00 OTHER REVENUE - BAD DEBT	B	-352	ADMINISTRATIVE & GENERAL		5.00	0	36.00
37.00 OTHER REVENUE - MEDICARE	B	-40	ADMINISTRATIVE & GENERAL		5.00	0	37.00
38.00 OTHER REVENUE - BLUE CROSS	B	-26	ADMINISTRATIVE & GENERAL		5.00	0	38.00
39.00 OTHER REVENUE - MEDICAID	B	14	ADMINISTRATIVE & GENERAL		5.00	0	39.00
40.00 OTHER REVENUE - SCRAP SAL	B	-3,925	ADMINISTRATIVE & GENERAL		5.00	0	40.00
41.00 OTHER REVENUE - CASH OVER	B	41	ADMINISTRATIVE & GENERAL		5.00	0	41.00
42.00 OTHER REVENUE - REBATES	B	-24,036	ADMINISTRATIVE & GENERAL		5.00	0	42.00
43.00 OTHER REVENUE - VEHICLE	B	-3,600	ADMINISTRATIVE & GENERAL		5.00	0	43.00
44.00 MHL A/P DISCOUNTS	B	-114	ADMINISTRATIVE & GENERAL		5.00	0	44.00
45.01 MHL TELEPHONE-PAY PHONES	B	-12	ADMINISTRATIVE & GENERAL		5.00	0	45.01
45.02 MHL TELEPHONE SERVICE	B	-11,890	ADMINISTRATIVE & GENERAL		5.00	0	45.02
45.03 OTHER REVENUE - NUTRITIONALS	B	-1,416	DIETARY		10.00	0	45.03
45.04 OTHER REVENUE - REBATES	B	-1,072	DIETARY		10.00	0	45.04
45.05 MEALS ON WHEELS	B	-41,112	DIETARY		10.00	0	45.05
45.08 INTEREST INCOME	B	-1,324	NEW CAP REL COSTS-BLDG & FIXT		1.00	12	45.08
45.09 HIM MEDICAL RECORDS FEES	B	-23,396	MEDICAL RECORDS & LIBRARY		16.00	0	45.09
45.10 PATIENT TELEVISIONS	A	-624	OPERATION OF PLANT		7.00	0	45.10
45.11 PATIENT TELEVISIONS	A	-1,006	NEW CAP REL COSTS-BLDG & FIXT		1.00	9	45.11
45.12 PATIENT TELEPHONES	A	-2,590	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	45.12
45.13 PATIENT TELEPHONES	A	-3,257	NEW CAP REL COSTS-BLDG & FIXT		1.00	9	45.13
45.14 PATIENT TELEPHONES	A	-1,601	ADMINISTRATIVE & GENERAL		5.00	0	45.14
45.15 IHA & AHA LOBBYING FEES	A	-6,226	ADMINISTRATIVE & GENERAL		5.00	0	45.15
45.16 GIFT SHOP	A	-17,954	NEW CAP REL COSTS-BLDG & FIXT		1.00	9	45.16
45.17 GIFT SHOP	A	-11,964	OPERATION OF PLANT		7.00	0	45.17
45.18 ADVERTISING	A	-404,083	ADMINISTRATIVE & GENERAL		5.00	0	45.18
45.19 TAXES	A	-40,105	ADMINISTRATIVE & GENERAL		5.00	0	45.19
45.20 DONATION EXPENSE	A	-19,547	ADMINISTRATIVE & GENERAL		5.00	0	45.20
45.21 PHYSICIAN RECRUITMENT	A	-276,598	ADMINISTRATIVE & GENERAL		5.00	0	45.21
45.22 CAPITALIZED INTEREST	A	-6,091	NEW CAP REL COSTS-BLDG & FIXT		1.00	9	45.22
45.23 VENDING	A	-2,163	OPERATION OF PLANT		7.00	0	45.23
45.24 VENDING	A	-3,246	NEW CAP REL COSTS-BLDG & FIXT		1.00	9	45.24
45.25 HOSPITAL ASSESSMENT FEES	A	-1,759,865	ADMINISTRATIVE & GENERAL		5.00	0	45.25
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,525,643					50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150072

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

Worksheet A-8-2

Date/Time Prepared:  
5/27/2014 5:30 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	60.00	LABORATORY	24,000	0	24,000	208,000	312	1.00
2.00	65.00	RESPIRATORY THERAPY	32,566	32,566	0	159,800	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	25,000	0	25,000	159,800	325	3.00
4.00	90.00	CLINIC	1,569,006	1,533,960	35,046	142,500	416	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,650,572	1,566,526	84,046		1,053	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	60.00	LABORATORY	31,200	1,560	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	0	5,394	2.00
3.00	69.00	ELECTROCARDIOLOGY	24,969	1,248	0	0	0	3.00
4.00	90.00	CLINIC	28,500	1,425	0	0	479,126	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			84,669	4,233	0	0	484,520	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	60.00	LABORATORY	0	31,200	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	32,566	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	24,969	31	31	3.00
4.00	90.00	CLINIC	10,702	39,202	0	1,533,960	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			10,702	95,371	31	1,566,557	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150072

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/27/2014 5:30 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT		
		NEW BLDG & FIXT	MOB	OPS			
	0	1.00	1.01	1.02	4.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	3,993,796	3,993,796				1.00	
1.01 00101 MOB	252,874	0	252,874			1.01	
1.02 00102 OPS	147,484	0	0	147,484		1.02	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	7,853,406	30,482	0	0	7,883,888	4.00	
5.00 00500 ADMINISTRATIVE & GENERAL	5,866,828	135,693	24,967	3,565	846,798	5.00	
7.00 00700 OPERATION OF PLANT	2,245,320	838,001	0	0	138,014	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	192,787	13,372	0	0	0	8.00	
9.00 00900 HOUSEKEEPING	700,503	41,068	0	0	149,652	9.00	
10.00 01000 DIETARY	243,256	142,913	0	0	58,886	10.00	
11.00 01100 CAFETERIA	418,706	104,097	0	0	141,579	11.00	
13.00 01300 NURSING ADMINISTRATION	454,430	78,259	0	0	133,770	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	1,610,419	148,044	0	0	48,986	14.00	
15.00 01500 PHARMACY	1,631,396	44,968	0	0	122,483	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	542,467	34,103	0	0	145,394	16.00	
17.00 01700 SOCIAL SERVICE	247,678	10,958	0	0	66,666	17.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	2,157,967	702,123	0	0	591,847	30.00	
31.00 03100 INTENSIVE CARE UNIT	540,294	95,902	0	0	152,547	31.00	
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00	
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00	
43.00 04300 NURSERY	239,042	9,193	0	0	65,845	43.00	
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	2,075,756	331,259	0	0	409,746	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	501,711	82,112	0	0	138,199	52.00	
53.00 05300 ANESTHESIOLOGY	18,301	38,770	0	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,843,690	238,212	0	10,142	291,932	54.00	
57.00 05700 CT SCAN	0	0	0	0	0	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00 06000 LABORATORY	2,473,277	89,774	7,300	4,906	289,981	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	217,599	0	0	0	13,775	63.00	
65.00 06500 RESPIRATORY THERAPY	505,908	71,387	0	0	142,987	65.00	
66.00 06600 PHYSICAL THERAPY	503,895	56,135	0	0	11,688	66.00	
69.00 06900 ELECTROCARDIOLOGY	287,714	0	7,523	0	63,090	69.00	
69.01 06901 CARDIAC REHAB	87,149	23,680	0	0	24,637	69.01	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	502,381	0	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
76.00 03020 NUCLEAR MEDICINE-DIAGNOSTIC	420,424	55,949	15,254	0	56,572	76.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	2,425,142	1,393	67,716	0	1,019,097	90.00	
91.00 09100 EMERGENCY	1,499,910	251,259	0	0	438,288	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00	
93.01 04041 FAMILY PRACTICE	0	0	0	0	0	93.01	
93.02 04042 FAMILY PRACTICE	0	0	0	0	0	93.02	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00 09500 AMBULANCE SERVICES	699	0	0	0	0	95.00	
99.10 09910 CORF	0	0	0	0	0	99.10	
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	42,702,209	3,669,106	122,760	18,613	5,562,459	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00 07950 FOUNDATION	3,253	1,672	0	0	0	194.00	
194.01 07951 MOB	4,692	0	130,114	0	0	194.01	
194.02 07952 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02	
194.03 07953 PIH	0	0	0	0	0	194.03	
194.04 07954 HEALTH COMPANIES	868,576	0	0	0	195,569	194.04	
194.05 07955 PHYSICIANS OFFICE	9,187,546	104,469	0	0	2,125,860	194.05	
194.06 07956 THE ARBORS	104	218,549	0	0	0	194.06	
194.08 07958 OPS	0	0	0	128,871	0	194.08	
200.00	Cross Foot Adjustments					200.00	
201.00	Negative Cost Centers					201.00	
202.00	TOTAL (sum lines 118-201)	52,766,380	3,993,796	252,874	147,484	7,883,888	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150072

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

Worksheet B Part I Date/Time Prepared: 5/27/2014 5:30 pm

Cost Center Description		Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4A	5.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	OPS					1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,877,851	6,877,851			5.00
7.00	00700	OPERATION OF PLANT	3,221,335	482,820	3,704,155		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	206,159	30,900	11,015	248,074	8.00
9.00	00900	HOUSEKEEPING	891,223	133,578	33,830	0	1,058,631
10.00	01000	DIETARY	445,055	66,706	117,725	3,496	13,686
11.00	01100	CAFETERIA	664,382	99,579	85,750	8,408	9,987
13.00	01300	NURSING ADMINISTRATION	666,459	99,890	64,465	0	3,699
14.00	01400	CENTRAL SERVICES & SUPPLY	1,807,449	270,904	121,951	117	8,877
15.00	01500	PHARMACY	1,798,847	269,615	37,042	0	8,877
16.00	01600	MEDICAL RECORDS & LIBRARY	721,964	108,209	28,092	0	4,439
17.00	01700	SOCIAL SERVICE	325,302	48,757	9,026	0	1,480
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	3,451,937	517,383	578,374	65,498	353,059
31.00	03100	INTENSIVE CARE UNIT	788,743	118,218	78,999	10,751	59,183
41.00	04100	SUBPROVIDER - IIRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	314,080	47,075	7,573	4,985	3,144
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	2,816,761	422,182	272,874	44,917	59,183
52.00	05200	DELIVERY ROOM & LABOR ROOM	722,022	108,218	67,640	0	28,482
53.00	05300	ANESTHESIOLOGY	57,071	8,554	31,936	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,383,976	357,315	227,455	18,800	72,684
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	2,865,238	429,448	114,627	582	21,269
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	231,374	34,679	0	0	0
65.00	06500	RESPIRATORY THERAPY	720,282	107,957	58,805	2,507	18,495
66.00	06600	PHYSICAL THERAPY	571,718	85,690	46,241	8,582	17,015
69.00	06900	ELECTROCARDIOLOGY	358,327	53,707	26,352	34	7,398
69.01	06901	CARDIAC REHAB	135,466	20,304	19,506	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	502,381	75,298	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	548,199	82,165	99,519	5,062	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	3,513,348	526,588	238,337	0	28,112
91.00	09100	EMERGENCY	2,189,457	328,160	206,974	46,592	96,172
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
93.01	04041	FAMILY PRACTICE	0	0	0	0	0
93.02	04042	FAMILY PRACTICE	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	699	105	0	0	0
99.10	09910	CORF	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	39,797,105	4,934,004	2,584,108	220,331	815,241
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07950	FOUNDATION	4,925	738	1,377	0	11,837
194.01	07951	MOB	134,806	20,205	455,752	0	0
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.03	07953	PIH	0	0	0	0	0
194.04	07954	HEALTH COMPANIES	1,064,145	159,496	0	0	14,796
194.05	07955	PHYSICIANS OFFICE	11,417,875	1,711,321	86,056	1,314	0
194.06	07956	THE ARBORS	218,653	32,772	180,029	26,429	41,428
194.08	07958	OPS	128,871	19,315	396,833	0	175,329
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)	52,766,380	6,877,851	3,704,155	248,074	1,058,631

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150072

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/27/2014 5:30 pm

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 MOB						1.01
1.02	00102 OPS						1.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DIETARY	646,668					10.00
11.00	01100 CAFETERIA	0	868,106				11.00
13.00	01300 NURSING ADMINISTRATION	0	13,993	848,506			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	12,530	0	2,221,828		14.00
15.00	01500 PHARMACY	0	27,020	0	0	2,141,401	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	33,373	0	0	0	16.00
17.00	01700 SOCIAL SERVICE	0	10,952	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	339,096	101,352	296,788	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	41,687	25,287	74,048	0	0	31.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300 NURSERY	0	9,255	27,102	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	61,984	181,508	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	19,427	56,888	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	44,870	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	63,829	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	2,484	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	22,081	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	2,917	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	15,137	0	0	0	69.00
69.01	06901 CARDIAC REHAB	0	5,870	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,221,828	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	2,141,401	73.00
76.00	03020 NUCLEAR MEDICINE-DIAGNOSTIC	0	7,262	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	117,182	0	0	0	90.00
91.00	09100 EMERGENCY	0	72,456	212,172	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04041 FAMILY PRACTICE	0	0	0	0	0	93.01
93.02	04042 FAMILY PRACTICE	0	0	0	0	0	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910 CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	380,783	669,261	848,506	2,221,828	2,141,401	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07950 FOUNDATION	0	0	0	0	0	194.00
194.01	07951 MOB	0	0	0	0	0	194.01
194.02	07952 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953 PIH	0	0	0	0	0	194.03
194.04	07954 HEALTH COMPANIES	0	28,786	0	0	0	194.04
194.05	07955 PHYSICIANS OFFICE	0	170,059	0	0	0	194.05
194.06	07956 THE ARBORS	265,885	0	0	0	0	194.06
194.08	07958 OPS	0	0	0	0	0	194.08
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)	646,668	868,106	848,506	2,221,828	2,141,401	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150072

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/27/2014 5:30 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	OPS					1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	896,077				16.00
17.00	01700	SOCIAL SERVICE	0	395,517			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	168,630	362,597	6,234,714	0	6,234,714
31.00	03100	INTENSIVE CARE UNIT	21,041	17,041	1,234,998	0	1,234,998
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	1,084	414,298	0	414,298
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	495,205	0	4,354,614	0	4,354,614
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,002,677	0	1,002,677
53.00	05300	ANESTHESIOLOGY	0	0	97,561	0	97,561
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,105,100	0	3,105,100
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	3,494,993	0	3,494,993
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	268,537	0	268,537
65.00	06500	RESPIRATORY THERAPY	0	0	930,127	0	930,127
66.00	06600	PHYSICAL THERAPY	0	0	732,163	0	732,163
69.00	06900	ELECTROCARDIOLOGY	0	0	460,955	0	460,955
69.01	06901	CARDIAC REHAB	0	0	181,146	0	181,146
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,221,828	0	2,221,828
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	577,679	0	577,679
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,141,401	0	2,141,401
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	742,207	0	742,207
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	1,239	4,424,806	0	4,424,806
91.00	09100	EMERGENCY	211,201	13,556	3,376,740	0	3,376,740
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
93.01	04041	FAMILY PRACTICE	0	0	0	0	93.01
93.02	04042	FAMILY PRACTICE	0	0	0	0	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	804	0	804
99.10	09910	CORF	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	896,077	395,517	35,997,348	0	35,997,348
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07950	FOUNDATION	0	0	18,877	0	18,877
194.01	07951	MOB	0	0	610,763	0	610,763
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	0	0	1,267,223	0	1,267,223
194.05	07955	PHYSICIANS OFFICE	0	0	13,386,625	0	13,386,625
194.06	07956	THE ARBORS	0	0	765,196	0	765,196
194.08	07958	OPS	0	0	720,348	0	720,348
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)	896,077	395,517	52,766,380	0	52,766,380

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150072

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/27/2014 5:30 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
		NEW BLDG & FIXT	MOB	OPS		
		0	1.00	1.01		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	MOB					1.01
1.02 00102	OPS					1.02
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	30,482	0	0	30,482 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	135,693	24,967	3,565	164,225 5.00
7.00 00700	OPERATION OF PLANT	0	838,001	0	0	838,001 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	13,372	0	0	13,372 8.00
9.00 00900	HOUSEKEEPING	0	41,068	0	0	41,068 9.00
10.00 01000	DIETARY	0	142,913	0	0	142,913 10.00
11.00 01100	CAFETERIA	0	104,097	0	0	104,097 11.00
13.00 01300	NURSING ADMINISTRATION	0	78,259	0	0	78,259 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	148,044	0	0	148,044 14.00
15.00 01500	PHARMACY	0	44,968	0	0	44,968 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	34,103	0	0	34,103 16.00
17.00 01700	SOCIAL SERVICE	0	10,958	0	0	10,958 17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	702,123	0	0	702,123 30.00
31.00 03100	INTENSIVE CARE UNIT	0	95,902	0	0	95,902 31.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0 41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0 42.00
43.00 04300	NURSERY	0	9,193	0	0	9,193 43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	331,259	0	0	331,259 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	82,112	0	0	82,112 52.00
53.00 05300	ANESTHESIOLOGY	0	38,770	0	0	38,770 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	238,212	0	10,142	248,354 54.00
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	0	89,774	7,300	4,906	101,980 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0 63.00
65.00 06500	RESPIRATORY THERAPY	0	71,387	0	0	71,387 65.00
66.00 06600	PHYSICAL THERAPY	0	56,135	0	0	56,135 66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	7,523	0	7,523 69.00
69.01 06901	CARDIAC REHAB	0	23,680	0	0	23,680 69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00 03020	NUCLEAR MEDICINE-DIAGNOSTIC	0	55,949	15,254	0	71,203 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	1,393	67,716	0	69,109 90.00
91.00 09100	EMERGENCY	0	251,259	0	0	251,259 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
93.00 04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0 93.00
93.01 04041	FAMILY PRACTICE	0	0	0	0	0 93.01
93.02 04042	FAMILY PRACTICE	0	0	0	0	0 93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
99.10 09910	CORF	0	0	0	0	0 99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	3,669,106	122,760	18,613	3,810,479 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
194.00 07950	FOUNDATION	0	1,672	0	0	1,672 194.00
194.01 07951	MOB	0	0	130,114	0	130,114 194.01
194.02 07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.02
194.03 07953	PIH	0	0	0	0	0 194.03
194.04 07954	HEALTH COMPANIES	0	0	0	0	0 194.04
194.05 07955	PHYSICIANS OFFICE	0	104,469	0	0	104,469 194.05
194.06 07956	THE ARBORS	0	218,549	0	0	218,549 194.06
194.08 07958	OPS	0	0	0	128,871	128,871 194.08
200.00	Cross Foot Adjustments					0 200.00
201.00	Negative Cost Centers					0 201.00
202.00	TOTAL (sum lines 118-201)	0	3,993,796	252,874	147,484	4,394,154 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150072

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/27/2014 5:30 pm

Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4.00	5.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 MOB						1.01
1.02	00102 OPS						1.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	30,482					4.00
5.00	00500 ADMINISTRATIVE & GENERAL	3,274	167,499				5.00
7.00	00700 OPERATION OF PLANT	534	11,758	850,293			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	752	2,529	16,653		8.00
9.00	00900 HOUSEKEEPING	579	3,253	7,766	0	52,666	9.00
10.00	01000 DIETARY	228	1,624	27,024	235	681	10.00
11.00	01100 CAFETERIA	547	2,425	19,684	564	497	11.00
13.00	01300 NURSING ADMINISTRATION	517	2,433	14,798	0	184	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	189	6,597	27,994	8	442	14.00
15.00	01500 PHARMACY	474	6,566	8,503	0	442	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	562	2,635	6,449	0	221	16.00
17.00	01700 SOCIAL SERVICE	258	1,187	2,072	0	74	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	2,289	12,600	132,764	4,397	17,565	30.00
31.00	03100 INTENSIVE CARE UNIT	590	2,879	18,134	722	2,944	31.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300 NURSERY	255	1,146	1,738	335	156	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	1,584	10,281	62,639	3,015	2,944	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	534	2,635	15,527	0	1,417	52.00
53.00	05300 ANESTHESIOLOGY	0	208	7,331	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,129	8,702	52,213	1,262	3,616	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	1,121	10,458	26,313	39	1,058	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	53	845	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	553	2,629	13,499	168	920	65.00
66.00	06600 PHYSICAL THERAPY	45	2,087	10,615	576	846	66.00
69.00	06900 ELECTROCARDIOLOGY	244	1,308	6,049	2	368	69.00
69.01	06901 CARDIAC REHAB	95	494	4,478	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	1,834	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020 NUCLEAR MEDICINE-DIAGNOSTIC	219	2,001	22,845	340	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	3,941	12,824	54,710	0	1,399	90.00
91.00	09100 EMERGENCY	1,695	7,992	47,511	3,128	4,784	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04041 FAMILY PRACTICE	0	0	0	0	0	93.01
93.02	04042 FAMILY PRACTICE	0	0	0	0	0	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0	3	0	0	0	95.00
99.10	09910 CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	21,509	120,156	593,185	14,791	40,558	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07950 FOUNDATION	0	18	316	0	589	194.00
194.01	07951 MOB	0	492	104,619	0	0	194.01
194.02	07952 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953 PIH	0	0	0	0	0	194.03
194.04	07954 HEALTH COMPANIES	756	3,884	0	0	736	194.04
194.05	07955 PHYSICIANS OFFICE	8,217	41,681	19,754	88	0	194.05
194.06	07956 THE ARBORS	0	798	41,326	1,774	2,061	194.06
194.08	07958 OPS	0	470	91,093	0	8,722	194.08
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)	30,482	167,499	850,293	16,653	52,666	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150072

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/27/2014 5:30 pm

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 MOB						1.01
1.02	00102 OPS						1.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DIETARY	172,705					10.00
11.00	01100 CAFETERIA	0	127,814				11.00
13.00	01300 NURSING ADMINISTRATION	0	2,060	98,251			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	1,845	0	185,119		14.00
15.00	01500 PHARMACY	0	3,978	0	0	64,931	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	4,914	0	0	0	16.00
17.00	01700 SOCIAL SERVICE	0	1,613	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	90,562	14,922	34,367	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	11,133	3,723	8,574	0	0	31.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300 NURSERY	0	1,363	3,138	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	9,126	21,017	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	2,860	6,587	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	6,606	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	9,398	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	366	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	3,251	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	429	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	2,229	0	0	0	69.00
69.01	06901 CARDIAC REHAB	0	864	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	185,119	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	64,931	73.00
76.00	03020 NUCLEAR MEDICINE-DIAGNOSTIC	0	1,069	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	17,253	0	0	0	90.00
91.00	09100 EMERGENCY	0	10,668	24,568	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04041 FAMILY PRACTICE	0	0	0	0	0	93.01
93.02	04042 FAMILY PRACTICE	0	0	0	0	0	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910 CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	101,695	98,537	98,251	185,119	64,931	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07950 FOUNDATION	0	0	0	0	0	194.00
194.01	07951 MOB	0	0	0	0	0	194.01
194.02	07952 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953 PIH	0	0	0	0	0	194.03
194.04	07954 HEALTH COMPANIES	0	4,238	0	0	0	194.04
194.05	07955 PHYSICIANS OFFICE	0	25,039	0	0	0	194.05
194.06	07956 THE ARBORS	71,010	0	0	0	0	194.06
194.08	07958 OPS	0	0	0	0	0	194.08
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)	172,705	127,814	98,251	185,119	64,931	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150072

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/27/2014 5:30 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	OPS					1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	48,884				16.00
17.00	01700	SOCIAL SERVICE	0	16,162			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	9,203	14,817	1,035,609	0	1,035,609
31.00	03100	INTENSIVE CARE UNIT	1,148	696	146,445	0	146,445
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	44	17,368	0	17,368
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	27,006	0	468,871	0	468,871
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	111,672	0	111,672
53.00	05300	ANESTHESIOLOGY	0	0	46,309	0	46,309
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	321,882	0	321,882
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	150,367	0	150,367
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	1,264	0	1,264
65.00	06500	RESPIRATORY THERAPY	0	0	92,407	0	92,407
66.00	06600	PHYSICAL THERAPY	0	0	70,733	0	70,733
69.00	06900	ELECTROCARDIOLOGY	0	0	17,723	0	17,723
69.01	06901	CARDIAC REHAB	0	0	29,611	0	29,611
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	185,119	0	185,119
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	1,834	0	1,834
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	64,931	0	64,931
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	97,677	0	97,677
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	51	159,287	0	159,287
91.00	09100	EMERGENCY	11,527	554	363,686	0	363,686
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
93.01	04041	FAMILY PRACTICE	0	0	0	0	93.01
93.02	04042	FAMILY PRACTICE	0	0	0	0	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	3	0	3
99.10	09910	CORF	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	48,884	16,162	3,382,798	0	3,382,798
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07950	FOUNDATION	0	0	2,595	0	2,595
194.01	07951	MOB	0	0	235,225	0	235,225
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	0	0	9,614	0	9,614
194.05	07955	PHYSICIANS OFFICE	0	0	199,248	0	199,248
194.06	07956	THE ARBORS	0	0	335,518	0	335,518
194.08	07958	OPS	0	0	229,156	0	229,156
200.00		Cross Foot Adjustments			0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	48,884	16,162	4,394,154	0	4,394,154

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150072

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

Worksheet B-1  
Date/Time Prepared:  
5/27/2014 5:30 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
	NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	OPS (SQUARE FEET)			
	1.00	1.01	1.02			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	172,033				1.00
1.01 00101	MOB	0	46,317			1.01
1.02 00102	OPS	0	0	23,748		1.02
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,313	0	0	26,122,969	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	5,845	4,573	574	2,805,836	-6,877,851
7.00 00700	OPERATION OF PLANT	36,097	0	0	457,305	0
8.00 00800	LAUNDRY & LINEN SERVICE	576	0	0	0	0
9.00 00900	HOUSEKEEPING	1,769	0	0	495,866	0
10.00 01000	DIETARY	6,156	0	0	195,116	0
11.00 01100	CAFETERIA	4,484	0	0	469,118	0
13.00 01300	NURSING ADMINISTRATION	3,371	0	0	443,241	0
14.00 01400	CENTRAL SERVICES & SUPPLY	6,377	0	0	162,314	0
15.00 01500	PHARMACY	1,937	0	0	405,844	0
16.00 01600	MEDICAL RECORDS & LIBRARY	1,469	0	0	481,759	0
17.00 01700	SOCIAL SERVICE	472	0	0	220,896	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	30,244	0	0	1,961,064	0
31.00 03100	INTENSIVE CARE UNIT	4,131	0	0	505,460	0
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00 04200	SUBPROVIDER	0	0	0	0	0
43.00 04300	NURSERY	396	0	0	218,176	0
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	14,269	0	0	1,357,680	0
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,537	0	0	457,917	0
53.00 05300	ANESTHESIOLOGY	1,670	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	10,261	0	1,633	967,306	0
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 06000	LABORATORY	3,867	1,337	790	960,841	0
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	45,643	0
65.00 06500	RESPIRATORY THERAPY	3,075	0	0	473,781	0
66.00 06600	PHYSICAL THERAPY	2,418	0	0	38,727	0
69.00 06900	ELECTROCARDIOLOGY	0	1,378	0	209,048	0
69.01 06901	CARDIAC REHAB	1,020	0	0	81,635	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00 03020	NUCLEAR MEDICINE-DIAGNOSTIC	2,410	2,794	0	187,450	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	60	12,403	0	3,376,742	0
91.00 09100	EMERGENCY	10,823	0	0	1,452,251	0
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00 04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
93.01 04041	FAMILY PRACTICE	0	0	0	0	0
93.02 04042	FAMILY PRACTICE	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0
99.10 09910	CORF	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	158,047	22,485	2,997	18,431,016	-6,877,851
<b>NONREIMBURSABLE COST CENTERS</b>						
194.00 07950	FOUNDATION	72	0	0	0	0
194.01 07951	MOB	0	23,832	0	0	0
194.02 07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.03 07953	PIH	0	0	0	0	0
194.04 07954	HEALTH COMPANIES	0	0	0	648,012	0
194.05 07955	PHYSICIANS OFFICE	4,500	0	0	7,043,941	0
194.06 07956	THE ARBORS	9,414	0	0	0	0
194.08 07958	OPS	0	0	20,751	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)	3,993,796	252,874	147,484	7,883,888	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	23.215290	5.459637	6.210376	0.301799	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150072

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

Worksheet B-1  
Date/Time Prepared:  
5/27/2014 5:30 pm

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
		NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	OPS (SQUARE FEET)			
		1.00	1.01	1.02			
204.00	Cost to be allocated (per Wkst. B, Part II)				30,482	5A	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)				0.001167		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150072

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

Worksheet B-1  
Date/Time Prepared:  
5/27/2014 5:30 pm

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	OPS					1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	45,888,529				5.00
7.00	00700	OPERATION OF PLANT	3,221,335	193,696			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	206,159	576	319,061		8.00
9.00	00900	HOUSEKEEPING	891,223	1,769	0	5,724	9.00
10.00	01000	DIETARY	445,055	6,156	4,497	74	9,354 10.00
11.00	01100	CAFETERIA	664,382	4,484	10,814	54	0 11.00
13.00	01300	NURSING ADMINISTRATION	666,459	3,371	0	20	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,807,449	6,377	151	48	0 14.00
15.00	01500	PHARMACY	1,798,847	1,937	0	48	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	721,964	1,469	0	24	0 16.00
17.00	01700	SOCIAL SERVICE	325,302	472	0	8	0 17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	3,451,937	30,244	84,238	1,909	4,905 30.00
31.00	03100	INTENSIVE CARE UNIT	788,743	4,131	13,827	320	603 31.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0 41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0 42.00
43.00	04300	NURSERY	314,080	396	6,411	17	0 43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	2,816,761	14,269	57,770	320	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	722,022	3,537	0	154	0 52.00
53.00	05300	ANESTHESIOLOGY	57,071	1,670	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,383,976	11,894	24,180	393	0 54.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00	06000	LABORATORY	2,865,238	5,994	749	115	0 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0 60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	231,374	0	0	0	0 63.00
65.00	06500	RESPIRATORY THERAPY	720,282	3,075	3,225	100	0 65.00
66.00	06600	PHYSICAL THERAPY	571,718	2,418	11,038	92	0 66.00
69.00	06900	ELECTROCARDIOLOGY	358,327	1,378	44	40	0 69.00
69.01	06901	CARDIAC REHAB	135,466	1,020	0	0	0 69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	502,381	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	548,199	5,204	6,511	0	0 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	3,513,348	12,463	0	152	0 90.00
91.00	09100	EMERGENCY	2,189,457	10,823	59,924	520	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0 93.00
93.01	04041	FAMILY PRACTICE	0	0	0	0	0 93.01
93.02	04042	FAMILY PRACTICE	0	0	0	0	0 93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	699	0	0	0	0 95.00
99.10	09910	CORF	0	0	0	0	0 99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	32,919,254	135,127	283,379	4,408	5,508 118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07950	FOUNDATION	4,925	72	0	64	0 194.00
194.01	07951	MOB	134,806	23,832	0	0	0 194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.02
194.03	07953	PIH	0	0	0	0	0 194.03
194.04	07954	HEALTH COMPANIES	1,064,145	0	0	80	0 194.04
194.05	07955	PHYSICIANS OFFICE	11,417,875	4,500	1,690	0	0 194.05
194.06	07956	THE ARBORS	218,653	9,414	33,992	224	3,846 194.06
194.08	07958	OPS	128,871	20,751	0	948	0 194.08
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,877,851	3,704,155	248,074	1,058,631	646,668 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.149882	19.123549	0.777513	184.946017	69.132777 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	167,499	850,293	16,653	52,666	172,705 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.003650	4.389833	0.052194	9.200908	18.463224 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150072

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

Worksheet B-1  
Date/Time Prepared:  
5/27/2014 5:30 pm

Cost Center Description		CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION  (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS)	MEDICAL RECORDS & LIBRARY (REVENUE)	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	730,023					11.00
13.00	01300	11,767	243,672				13.00
14.00	01400	10,537	0	1,000			14.00
15.00	01500	22,722	0	0	1,000		15.00
16.00	01600	28,065	0	0	0	44,338,017	16.00
17.00	01700	9,210	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	85,231	85,231	0	0	8,343,870	30.00
31.00	03100	21,265	21,265	0	0	1,041,110	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	7,783	7,783	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	52,125	52,125	0	0	24,502,694	50.00
52.00	05200	16,337	16,337	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	37,733	0	0	0	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	53,676	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	2,089	0	0	0	0	63.00
65.00	06500	18,569	0	0	0	0	65.00
66.00	06600	2,453	0	0	0	0	66.00
69.00	06900	12,729	0	0	0	0	69.00
69.01	06901	4,936	0	0	0	0	69.01
71.00	07100	0	0	1,000	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	1,000	0	73.00
76.00	03020	6,107	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	98,543	0	0	0	0	90.00
91.00	09100	60,931	60,931	0	0	10,450,343	91.00
92.00	09200						92.00
93.00	04040	0	0	0	0	0	93.00
93.01	04041	0	0	0	0	0	93.01
93.02	04042	0	0	0	0	0	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00							
	SUBTOTALS (SUM OF LINES 1-117)	562,808	243,672	1,000	1,000	44,338,017	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07950	0	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	0	0	0	0	0	194.03
194.04	07954	24,207	0	0	0	0	194.04
194.05	07955	143,008	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.08	07958	0	0	0	0	0	194.08
200.00							200.00
201.00							201.00
202.00		868,106	848,506	2,221,828	2,141,401	896,077	202.00
203.00		1.189149	3.482165	2,221.828000	2,141.401000	0.020210	203.00
204.00		127,814	98,251	185,119	64,931	48,884	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150072

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

Worksheet B-1

Date/Time Prepared:  
5/27/2014 5:30 pm

Cost Center Description		CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION  (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS)	MEDICAL RECORDS & LIBRARY (REVENUE)	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.175082	0.403210	185.119000	64.931000	0.001103	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150072

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

Worksheet B-1  
Date/Time Prepared:  
5/27/2014 5:30 pm

Cost Center Description		SOCIAL SERVICE	
		(HOURS)	
		17.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101 MOB		1.01
1.02	00102 OPS		1.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE	25,530	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000 ADULTS & PEDIATRICS	23,405	30.00
31.00	03100 INTENSIVE CARE UNIT	1,100	31.00
41.00	04100 SUBPROVIDER - IRF	0	41.00
42.00	04200 SUBPROVIDER	0	42.00
43.00	04300 NURSERY	70	43.00
44.00	04400 SKILLED NURSING FACILITY	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000 OPERATING ROOM	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300 ANESTHESIOLOGY	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	54.00
57.00	05700 CT SCAN	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	59.00
60.00	06000 LABORATORY	0	60.00
60.01	06001 BLOOD LABORATORY	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	65.00
66.00	06600 PHYSICAL THERAPY	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	69.00
69.01	06901 CARDIAC REHAB	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03020 NUCLEAR MEDICINE-DIAGNOSTIC	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000 CLINIC	80	90.00
91.00	09100 EMERGENCY	875	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	93.00
93.01	04041 FAMILY PRACTICE	0	93.01
93.02	04042 FAMILY PRACTICE	0	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>			
95.00	09500 AMBULANCE SERVICES	0	95.00
99.10	09910 CORF	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>			
118.00	SUBTOTALS (SUM OF LINES 1-117)	25,530	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
194.00	07950 FOUNDATION	0	194.00
194.01	07951 MOB	0	194.01
194.02	07952 OTHER NONREIMBURSABLE COST CENTERS	0	194.02
194.03	07953 PIH	0	194.03
194.04	07954 HEALTH COMPANIES	0	194.04
194.05	07955 PHYSICIANS OFFICE	0	194.05
194.06	07956 THE ARBORS	0	194.06
194.08	07958 OPS	0	194.08
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)	395,517	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	15.492244	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	16,162	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.633059	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150072

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/27/2014 5:30 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		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS		6,234,714	0	6,234,714	30.00	
31.00	03100 INTENSIVE CARE UNIT		1,234,998	0	1,234,998	31.00	
41.00	04100 SUBPROVIDER - I RF		0	0	0	41.00	
42.00	04200 SUBPROVIDER		0	0	0	42.00	
43.00	04300 NURSERY		414,298	0	414,298	43.00	
44.00	04400 SKILLED NURSING FACILITY		0	0	0	44.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM		4,354,614	0	4,354,614	50.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM		1,002,677	0	1,002,677	52.00	
53.00	05300 ANESTHESIOLOGY		97,561	0	97,561	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		3,105,100	0	3,105,100	54.00	
57.00	05700 CT SCAN		0	0	0	57.00	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00	
60.00	06000 LABORATORY		3,494,993	0	3,494,993	60.00	
60.01	06001 BLOOD LABORATORY		0	0	0	60.01	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		268,537	0	268,537	63.00	
65.00	06500 RESPIRATORY THERAPY	0	930,127	0	930,127	65.00	
66.00	06600 PHYSICAL THERAPY	0	732,163	0	732,163	66.00	
69.00	06900 ELECTROCARDIOLOGY		460,955	31	460,986	69.00	
69.01	06901 CARDIAC REHAB		181,146	0	181,146	69.01	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		2,221,828	0	2,221,828	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		577,679	0	577,679	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		2,141,401	0	2,141,401	73.00	
76.00	03020 NUCLEAR MEDICINE-DIAGNOSTIC		742,207	0	742,207	76.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC		4,424,806	0	4,424,806	90.00	
91.00	09100 EMERGENCY		3,376,740	0	3,376,740	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1,481,647		1,481,647	92.00	
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER		0	0	0	93.00	
93.01	04041 FAMILY PRACTICE		0	0	0	93.01	
93.02	04042 FAMILY PRACTICE		0	0	0	93.02	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES		804	0	804	95.00	
99.10	09910 CORF		0	0	0	99.10	
200.00	Subtotal (see instructions)		37,478,995	31	37,479,026	200.00	
201.00	Less Observation Beds		1,481,647		1,481,647	201.00	
202.00	Total (see instructions)		35,997,348	31	35,997,379	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150072

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/27/2014 5:30 pm

		Title XVIII			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	8,343,870		8,343,870		30.00
31.00	03100	INTENSIVE CARE UNIT	1,041,110		1,041,110		31.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	1,101,814		1,101,814		43.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	3,882,909	20,619,785	24,502,694	0.177720	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,711,281	185,091	1,896,372	0.528734	52.00
53.00	05300	ANESTHESIOLOGY	227,978	951,482	1,179,460	0.082717	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	996,033	12,047,799	13,043,832	0.238051	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	2,894,467	16,179,943	19,074,410	0.183229	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	350,716	385,133	735,849	0.364935	63.00
65.00	06500	RESPIRATORY THERAPY	1,947,934	1,744,994	3,692,928	0.251867	65.00
66.00	06600	PHYSICAL THERAPY	316,200	2,093,771	2,409,971	0.303806	66.00
69.00	06900	ELECTROCARDIOLOGY	531,631	2,600,856	3,132,487	0.147153	69.00
69.01	06901	CARDIAC REHAB	41	253,637	253,678	0.714078	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,722,932	6,268,693	7,991,625	0.278020	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	900,879	1,771,788	2,672,667	0.216143	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,359,174	3,079,538	6,438,712	0.332582	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	1,518,262	12,197,332	13,715,594	0.054114	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	8,447	1,450,749	1,459,196	3.032359	90.00
91.00	09100	EMERGENCY	1,142,992	9,307,351	10,450,343	0.323122	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	160,121	1,892,793	2,052,914	0.721729	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	93.00
93.01	04041	FAMILY PRACTICE	0	0	0	0.000000	93.01
93.02	04042	FAMILY PRACTICE	0	0	0	0.000000	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
99.10	09910	CORF	0	0	0	0.000000	99.10
200.00		Subtotal (see instructions)	32,158,791	93,030,735	125,189,526		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	32,158,791	93,030,735	125,189,526		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150072	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/27/2014 5:30 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.177720		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.528734		52.00
53.00	05300 ANESTHESIOLOGY	0.082717		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.238051		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.183229		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.364935		63.00
65.00	06500 RESPIRATORY THERAPY	0.251867		65.00
66.00	06600 PHYSICAL THERAPY	0.303806		66.00
69.00	06900 ELECTROCARDIOLOGY	0.147163		69.00
69.01	06901 CARDIAC REHAB	0.714078		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.278020		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.216143		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.332582		73.00
76.00	03020 NUCLEAR MEDICINE-DIAGNOSTIC	0.054114		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	3.032359		90.00
91.00	09100 EMERGENCY	0.323122		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.721729		92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
93.01	04041 FAMILY PRACTICE	0.000000		93.01
93.02	04042 FAMILY PRACTICE	0.000000		93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
99.10	09910 CORF			99.10
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150072

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/27/2014 5:30 pm

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		6,234,714	0	6,234,714	30.00
31.00	03100 INTENSIVE CARE UNIT		1,234,998	0	1,234,998	31.00
41.00	04100 SUBPROVIDER - I RF		0	0	0	41.00
42.00	04200 SUBPROVIDER		0	0	0	42.00
43.00	04300 NURSERY		414,298	0	414,298	43.00
44.00	04400 SKILLED NURSING FACILITY		0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		4,354,614	0	4,354,614	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		1,002,677	0	1,002,677	52.00
53.00	05300 ANESTHESIOLOGY		97,561	0	97,561	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		3,105,100	0	3,105,100	54.00
57.00	05700 CT SCAN		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	06000 LABORATORY		3,494,993	0	3,494,993	60.00
60.01	06001 BLOOD LABORATORY		0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		268,537	0	268,537	63.00
65.00	06500 RESPIRATORY THERAPY	0	930,127	0	930,127	65.00
66.00	06600 PHYSICAL THERAPY	0	732,163	0	732,163	66.00
69.00	06900 ELECTROCARDIOLOGY		460,955	31	460,986	69.00
69.01	06901 CARDIAC REHAB		181,146	0	181,146	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		2,221,828	0	2,221,828	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		577,679	0	577,679	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		2,141,401	0	2,141,401	73.00
76.00	03020 NUCLEAR MEDICINE-DIAGNOSTIC		742,207	0	742,207	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC		4,424,806	0	4,424,806	90.00
91.00	09100 EMERGENCY		3,376,740	0	3,376,740	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1,481,647		1,481,647	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER		0	0	0	93.00
93.01	04041 FAMILY PRACTICE		0	0	0	93.01
93.02	04042 FAMILY PRACTICE		0	0	0	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES		804	0	804	95.00
99.10	09910 CORF		0	0	0	99.10
200.00	Subtotal (see instructions)		37,478,995	31	37,479,026	200.00
201.00	Less Observation Beds		1,481,647		1,481,647	201.00
202.00	Total (see instructions)		35,997,348	31	35,997,379	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150072

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/27/2014 5:30 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	8,343,870		8,343,870		30.00
31.00	03100	INTENSIVE CARE UNIT	1,041,110		1,041,110		31.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	1,101,814		1,101,814		43.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	3,882,909	20,619,785	24,502,694	0.177720	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,711,281	185,091	1,896,372	0.528734	52.00
53.00	05300	ANESTHESIOLOGY	227,978	951,482	1,179,460	0.082717	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	996,033	12,047,799	13,043,832	0.238051	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	2,894,467	16,179,943	19,074,410	0.183229	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	350,716	385,133	735,849	0.364935	63.00
65.00	06500	RESPIRATORY THERAPY	1,947,934	1,744,994	3,692,928	0.251867	65.00
66.00	06600	PHYSICAL THERAPY	316,200	2,093,771	2,409,971	0.303806	66.00
69.00	06900	ELECTROCARDIOLOGY	531,631	2,600,856	3,132,487	0.147153	69.00
69.01	06901	CARDIAC REHAB	41	253,637	253,678	0.714078	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,722,932	6,268,693	7,991,625	0.278020	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	900,879	1,771,788	2,672,667	0.216143	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,359,174	3,079,538	6,438,712	0.332582	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	1,518,262	12,197,332	13,715,594	0.054114	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	8,447	1,450,749	1,459,196	3.032359	90.00
91.00	09100	EMERGENCY	1,142,992	9,307,351	10,450,343	0.323122	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	160,121	1,892,793	2,052,914	0.721729	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	93.00
93.01	04041	FAMILY PRACTICE	0	0	0	0.000000	93.01
93.02	04042	FAMILY PRACTICE	0	0	0	0.000000	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
99.10	09910	CORF	0	0	0	0.000000	99.10
200.00		Subtotal (see instructions)	32,158,791	93,030,735	125,189,526		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	32,158,791	93,030,735	125,189,526		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150072	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/27/2014 5:30 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901 CARDIAC REHAB	0.000000		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020 NUCLEAR MEDICINE-DIAGNOSTIC	0.000000		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
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
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
93.01	04041 FAMILY PRACTICE	0.000000		93.01
93.02	04042 FAMILY PRACTICE	0.000000		93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
99.10	09910 CORF			99.10
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 150072

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

Worksheet D  
Part I  
Date/Time Prepared:  
5/27/2014 5:30 pm

Cost Center Description		Title XVIII			Hospital		Per Diem (col. 3 / col. 4)	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	1,035,609	0	1,035,609	6,434	160.96	30.00	
31.00	INTENSIVE CARE UNIT	146,445		146,445	603	242.86	31.00	
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00	
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00	
43.00	NURSERY	17,368		17,368	963	18.04	43.00	
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00	
200.00	Total (lines 30-199)	1,199,422		1,199,422	8,000		200.00	
Cost Center Description		Title XVIII		Hospital		Per Diem (col. 3 / col. 4)		
		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Total Patient Days	PPS			
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	2,462	396,284				30.00	
31.00	INTENSIVE CARE UNIT	392	95,201				31.00	
41.00	SUBPROVIDER - IRF	0	0				41.00	
42.00	SUBPROVIDER	0	0				42.00	
43.00	NURSERY	0	0				43.00	
44.00	SKILLED NURSING FACILITY	0	0				44.00	
200.00	Total (lines 30-199)	2,854	491,485				200.00	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150072

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

Worksheet D  
Part II  
Date/Time Prepared:  
5/27/2014 5:30 pm

Cost Center Description		Title XVIII			Hospital	PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	468,871	24,502,694	0.019135	1,303,076	24,934	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	111,672	1,896,372	0.058887	11,304	666	52.00
53.00	05300 ANESTHESIOLOGY	46,309	1,179,460	0.039263	64,823	2,545	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	321,882	13,043,832	0.024677	667,012	16,460	54.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	150,367	19,074,410	0.007883	1,777,072	14,009	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1,264	735,849	0.001718	181,347	312	63.00
65.00	06500 RESPIRATORY THERAPY	92,407	3,692,928	0.025023	1,450,538	36,297	65.00
66.00	06600 PHYSICAL THERAPY	70,733	2,409,971	0.029350	245,972	7,219	66.00
69.00	06900 ELECTROCARDIOLOGY	17,723	3,132,487	0.005658	253,859	1,436	69.00
69.01	06901 CARDIAC REHAB	29,611	253,678	0.116727	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	185,119	7,991,625	0.023164	1,299,330	30,098	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1,834	2,672,667	0.000686	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	64,931	6,438,712	0.010084	2,099,522	21,172	73.00
76.00	03020 NUCLEAR MEDICINE-DIAGNOSTIC	97,677	13,715,594	0.007122	864,335	6,156	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	159,287	1,459,196	0.109161	6,689	730	90.00
91.00	09100 EMERGENCY	363,686	10,450,343	0.034801	723,228	25,169	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	246,107	2,052,914	0.119882	61,667	7,393	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
93.01	04041 FAMILY PRACTICE	0	0	0.000000	0	0	93.01
93.02	04042 FAMILY PRACTICE	0	0	0.000000	0	0	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	2,429,480	114,702,732		11,009,774	194,596	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150072	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part III Date/Time Prepared: 5/27/2014 5:30 pm
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Cost Center Description			Title XVIII		Hospital		PPS	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
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
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,434	0.00	2,462	0		30.00
31.00	03100	INTENSIVE CARE UNIT	603	0.00	392	0		31.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0		41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0		42.00
43.00	04300	NURSERY	963	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0		44.00
200.00		Total (lines 30-199)	8,000		2,854	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150072

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/27/2014 5:30 pm

Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00		5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	0	93.00
93.01	04041	FAMILY PRACTICE	0	0	0	0	0	0	93.01
93.02	04042	FAMILY PRACTICE	0	0	0	0	0	0	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150072

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/27/2014 5:30 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital			
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	24,502,694	0.000000	0.000000	1,303,076	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,896,372	0.000000	0.000000	11,304	52.00
53.00	05300	ANESTHESIOLOGY	0	1,179,460	0.000000	0.000000	64,823	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,043,832	0.000000	0.000000	667,012	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	19,074,410	0.000000	0.000000	1,777,072	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	735,849	0.000000	0.000000	181,347	63.00
65.00	06500	RESPIRATORY THERAPY	0	3,692,928	0.000000	0.000000	1,450,538	65.00
66.00	06600	PHYSICAL THERAPY	0	2,409,971	0.000000	0.000000	245,972	66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,132,487	0.000000	0.000000	253,859	69.00
69.01	06901	CARDIAC REHAB	0	253,678	0.000000	0.000000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,991,625	0.000000	0.000000	1,299,330	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,672,667	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,438,712	0.000000	0.000000	2,099,522	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0	13,715,594	0.000000	0.000000	864,335	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	1,459,196	0.000000	0.000000	6,689	90.00
91.00	09100	EMERGENCY	0	10,450,343	0.000000	0.000000	723,228	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,052,914	0.000000	0.000000	61,667	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
93.01	04041	FAMILY PRACTICE	0	0	0.000000	0.000000	0	93.01
93.02	04042	FAMILY PRACTICE	0	0	0.000000	0.000000	0	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	114,702,732			11,009,774	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150072

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/27/2014 5:30 pm

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XVIII Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	5,341,006	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	182,631	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	3,740,015	0	54.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	244,448	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	78,674	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	960,097	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	724,543	0	69.00
69.01	06901 CARDIAC REHAB	0	107,299	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,007,436	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,178,224	0	73.00
76.00	03020 NUCLEAR MEDICINE-DIAGNOSTIC	0	4,312,896	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	1,059,366	0	90.00
91.00	09100 EMERGENCY	0	2,218,475	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,047,681	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	93.00
93.01	04041 FAMILY PRACTICE	0	0	0	93.01
93.02	04042 FAMILY PRACTICE	0	0	0	93.02
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (lines 50-199)	0	23,202,791	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150072	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 5:30 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			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.177720	5,341,006	0	0	949,204	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.528734	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.082717	182,631	0	0	15,107	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.238051	3,740,015	3	429	890,314	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.183229	244,448	3,596	0	44,790	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.364935	78,674	0	0	28,711	63.00
65.00	06500	RESPIRATORY THERAPY	0.251867	960,097	3	361	241,817	65.00
66.00	06600	PHYSICAL THERAPY	0.303806	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.147153	724,543	0	0	106,619	69.00
69.01	06901	CARDIAC REHAB	0.714078	107,299	0	0	76,620	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.278020	2,007,436	0	0	558,107	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.216143	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.332582	1,178,224	97	13,047	391,856	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0.054114	4,312,896	77	10,394	233,388	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	3.032359	1,059,366	2	314	3,212,378	90.00
91.00	09100	EMERGENCY	0.323122	2,218,475	0	0	716,838	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.721729	1,047,681	0	0	756,142	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
93.01	04041	FAMILY PRACTICE	0.000000	0	0	0	0	93.01
93.02	04042	FAMILY PRACTICE	0.000000	0	0	0	0	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0.000000	0	0	0	0	95.00
200.00		Subtotal (see instructions)		23,202,791	3,778	24,545	8,221,891	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)		23,202,791	3,778	24,545	8,221,891	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150072	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 5:30 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		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1	102	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	659	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	1	91	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
69.01	06901 CARDIAC REHAB	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	32	4,339	73.00
76.00	03020 NUCLEAR MEDICINE-DIAGNOSTIC	4	562	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	6	952	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
93.01	04041 FAMILY PRACTICE	0	0	93.01
93.02	04042 FAMILY PRACTICE	0	0	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0		95.00
200.00	Subtotal (see instructions)	703	6,046	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	703	6,046	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150072	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/27/2014 5:30 pm
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,434	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,434	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,905	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,462	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,234,714	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)		6,234,714	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		6,234,714	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		969.03	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,385,752	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,385,752	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150072		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/27/2014 5:30 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)	
Title XVIII		1.00	2.00	3.00	4.00	5.00	
Hospital						PPS	
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	1,234,998	603	2,048.09	392	802,851	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,675,683	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,864,286	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)					491,485	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					194,596	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					686,081	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					5,178,205	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)					1,529	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					969.03	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,481,647	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150072		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/27/2014 5:30 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	1,035,609	6,234,714	0.166104	1,481,647	246,107	90.00
91.00	Nursing School cost	0	6,234,714	0.000000	1,481,647	0	91.00
92.00	Allied health cost	0	6,234,714	0.000000	1,481,647	0	92.00
93.00	All other Medical Education	0	6,234,714	0.000000	1,481,647	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150072	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/27/2014 5:30 pm
Cost Center Description			Cost	
			1.00	
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,434	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,434	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,905	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)		422	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)		963	15.00
16.00	Nursery days (title V or XIX only)		167	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,234,714	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)		6,234,714	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		6,234,714	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		969.03	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		408,931	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)		408,931	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150072		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
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)		414,298	963	430.22	167	71,847	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	1,234,998	603	2,048.09	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)					529,147	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,009,925	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)					1,529	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					969.03	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,481,647	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150072

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

Worksheet D-1  
Date/Time Prepared:  
5/27/2014 5:30 pm

Cost Center Description	Cost	Title XIX		Hospital	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: 150072	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/27/2014 5:30 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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		3,798,786		30.00
31.00	03100 INTENSIVE CARE UNIT		688,063		31.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.177720	1,303,076	231,583	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.528734	11,304	5,977	52.00
53.00	05300 ANESTHESIOLOGY	0.082717	64,823	5,362	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.238051	667,012	158,783	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.183229	1,777,072	325,611	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.364935	181,347	66,180	63.00
65.00	06500 RESPIRATORY THERAPY	0.251867	1,450,538	365,343	65.00
66.00	06600 PHYSICAL THERAPY	0.303806	245,972	74,728	66.00
69.00	06900 ELECTROCARDIOLOGY	0.147163	253,859	37,359	69.00
69.01	06901 CARDIAC REHAB	0.714078	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.278020	1,299,330	361,240	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.216143	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.332582	2,099,522	698,263	73.00
76.00	03020 NUCLEAR MEDICINE-DIAGNOSTIC	0.054114	864,335	46,773	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	3.032359	6,689	20,283	90.00
91.00	09100 EMERGENCY	0.323122	723,228	233,691	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.721729	61,667	44,507	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
93.01	04041 FAMILY PRACTICE	0.000000	0	0	93.01
93.02	04042 FAMILY PRACTICE	0.000000	0	0	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		11,009,774	2,675,683	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)		11,009,774		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150072	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/27/2014 5:30 pm
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		530,426		30.00
31.00	03100 INTENSIVE CARE UNIT		35,680		31.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY		321,085		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.177720	415,957	73,924	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.528734	447,463	236,589	52.00
53.00	05300 ANESTHESIOLOGY	0.082717	28,783	2,381	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.238051	36,014	8,573	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.183229	173,335	31,760	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.364935	29,616	10,808	63.00
65.00	06500 RESPIRATORY THERAPY	0.251867	80,338	20,234	65.00
66.00	06600 PHYSICAL THERAPY	0.303806	9,482	2,881	66.00
69.00	06900 ELECTROCARDIOLOGY	0.147153	7,445	1,096	69.00
69.01	06901 CARDIAC REHAB	0.714078	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.278020	204,855	56,954	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.216143	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.332582	201,378	66,975	73.00
76.00	03020 NUCLEAR MEDICINE-DIAGNOSTIC	0.054114	38,268	2,071	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	3.032359	0	0	90.00
91.00	09100 EMERGENCY	0.323122	42,612	13,769	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.721729	1,568	1,132	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
93.01	04041 FAMILY PRACTICE	0.000000	0	0	93.01
93.02	04042 FAMILY PRACTICE	0.000000	0	0	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		1,717,114	529,147	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)		1,717,114		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150072	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3	
		Component CCN: 15U072	Date/Time Prepared: 5/27/2014 5:30 pm		
		Title XIX	Swing Beds - SNF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.177720	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.528734	0	52.00
53.00	05300	ANESTHESIOLOGY	0.082717	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.238051	0	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.183229	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.364935	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.251867	0	65.00
66.00	06600	PHYSICAL THERAPY	0.303806	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.147153	0	69.00
69.01	06901	CARDIAC REHAB	0.714078	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.278020	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.216143	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.332582	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0.054114	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	3.032359	0	90.00
91.00	09100	EMERGENCY	0.323122	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.721729	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	93.00
93.01	04041	FAMILY PRACTICE	0.000000	0	93.01
93.02	04042	FAMILY PRACTICE	0.000000	0	93.02
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		0	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)		0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150072	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/27/2014 5:30 pm
		Title XVIII	Hospital	PPS
		0	1.00	2.00
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER PPS</b>				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013 (see instructions)		3,054,387	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		1,078,326	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)		25,567	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)		78.81	4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
29.00	Total IME payment ( sum of lines 22 and 28)		0	29.00
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.64	30.00
31.00	Percentage of Medicaid patient days (see instructions)		24.39	31.00
32.00	Sum of lines 30 and 31		28.03	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.00	33.00
34.00	Disproportionate share adjustment (see instructions)		398,876	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150072	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/27/2014 5:30 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)			0.000056630	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			512,292	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			129,126	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		129,126		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)			0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)			0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)			0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41)			0	46.00
47.00	Subtotal (see instructions)		4,686,282		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		6,082,502		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		6,082,502		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		327,991		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)		6,410,493		59.00
60.00	Primary payer payments		14,703		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		6,395,790		61.00
62.00	Deductibles billed to program beneficiaries		659,068		62.00
63.00	Coinurance billed to program beneficiaries		7,992		63.00
64.00	Allowable bad debts (see instructions)		64,523		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		41,940		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		64,523		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		5,770,670		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)		9,202		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)	2013	553,248		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2014	218,887		70.97
70.98	Low Volume Payment-3		0		70.98

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150072	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/27/2014 5:30 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)		6,552,007		71.00
71.01	Sequestration adjustment (see instructions)		98,935		71.01
72.00	Interim payments		6,502,198		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		-49,126		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		231,860		75.00
<b>TO BE COMPLETED BY CONTRACTOR</b>					
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the Time Value of Money		0.00		94.00
95.00	Time Value of Money for operating expenses(see instructions)		0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)		0		96.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150072

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

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
5/27/2014 5:30 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	3,054,387	0	3,054,387	0	3,054,387	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013	1.02	1,078,326	0	0	1,078,326	1,078,326	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	25,567	0	25,567	0	25,567	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
<b>Indirect Medical Education Adjustment</b>								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>								
7.00	Amount from Worksheet E Part A, line 27 (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
<b>Disproportionate Share Adjustment</b>								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	398,876	0	366,526	32,350	398,876	11.00
11.01	Uncompensated care payments	36.00	129,126	0	0	129,126	129,126	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	4,686,282	0	3,446,480	1,239,802	4,686,282	13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	48.00	6,082,502	0	4,508,827	1,573,675	6,082,502	14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49.00	6,082,502	0	4,508,827	1,573,675	6,082,502	15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50.00	327,991	0	242,977	85,014	327,991	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	4,751,804	1,658,689	6,410,493	19.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150072

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

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
5/27/2014 5:30 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	324,443	0	239,429	85,014	324,443	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	3,548	0	3,548	0	3,548	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	327,991	0	242,977	85,014	327,991	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				0.116429	0.131964		27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.96			553,248		553,248	28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.97				218,887	218,887	29.00
100.00	Transfer low volume adjustments to W/S E Part A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150072	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/27/2014 5:30 pm
		Title XVII	Hospital	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			6,749 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			8,221,891 2.00
3.00	PPS payments			5,502,995 3.00
4.00	Outlier payment (see instructions)			74,214 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)			6,749 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges			28,323 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			28,323 14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			28,323 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			21,574 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)			6,749 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)			5,577,209 24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)			0 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,361,746 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			4,222,212 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			4,222,212 30.00
31.00	Primary payer payments			1,942 31.00
32.00	Subtotal (line 30 minus line 31)			4,220,270 32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			163,273 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			106,127 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			163,273 36.00
37.00	Subtotal (see instructions)			4,326,397 37.00
38.00	MSP-LCC reconciliation amount from PS&R			38 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			4,326,359 40.00
40.01	Sequestration adjustment (see instructions)			65,328 40.01
41.00	Interim payments			4,230,474 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			30,557 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150072

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/27/2014 5:30 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		6,224,991		4,152,814	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		218,887		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	01/01/2013	58,320	01/01/2013	77,660	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)		58,320		77,660	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		6,502,198		4,230,474	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		30,557	6.01
6.02	SETTLEMENT TO PROGRAM		49,126		0	6.02
7.00	Total Medicare program liability (see instructions)		6,453,072		4,261,031	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: 150072

Period:

Worksheet E-1

Component CCN: 15U072

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

Part I  
Date/Time Prepared:  
5/27/2014 5:30 pm

Title XVIII

Swing Beds - SNF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		0		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 150072

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

Worksheet E-1  
Part II  
Date/Time Prepared:  
5/27/2014 5:30 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			1,715 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			2,854 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			365 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			5,508 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			125,189,526 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			3,013,036 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)			949,196 8.00
9.00	Sequestration adjustment amount (see instructions)			18,984 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			930,212 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			945,207 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)			-14,995 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 150072	Period: From 01/01/2013 To 12/31/2013	Worksheet E-2
		Component CCN: 15U072		Date/Time Prepared: 5/27/2014 5:30 pm
		Title XVIII	Swing Beds - SNF	PPS
		Part A	Part B	
		1.00	2.00	
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 6 and 7, line 202 for Part B) (For CAH, see instructions)			3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	0	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	0	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	0	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	0	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	0	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
20.00	Interim payments	0	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21	0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 150072	Period: From 01/01/2013 To 12/31/2013	Worksheet E-2
		Component CCN: 15U072		Date/Time Prepared: 5/27/2014 5:30 pm
		Title XIX	Swing Beds - SNF	PPS
		Part A	Part B	
		1.00	2.00	
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)		0	2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 6 and 7, line 202 for Part B) (For CAH, see instructions)		0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days		0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	8.00
9.00	Primary payer payments (see instructions)		0	9.00
10.00	Subtotal (line 8 minus line 9)		0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	11.00
12.00	Subtotal (line 10 minus line 11)		0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)		0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	16.00
17.00	Allowable bad debts (see instructions)		0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	18.00
19.00	Total (see instructions)		0	19.00
19.01	Sequestration adjustment (see instructions)		0	19.01
20.00	Interim payments		0	20.00
21.00	Tentative settlement (for contractor use only)		0	21.00
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21		0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150072	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part VII Date/Time Prepared: 5/27/2014 5:30 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		1,009,925		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)		1,009,925	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)		1,009,925	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		887,191		8.00
9.00	Ancillary service charges		1,717,114	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)		2,604,305	0	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		2,604,305	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		1,594,380	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		1,009,925	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		1,009,925	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1,009,925	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		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		1,009,925	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		1,009,925	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		1,009,925	0	40.00
41.00	Interim payments		1,041,391	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		-31,466	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: 150072

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

Worksheet G

Date/Time Prepared:  
5/27/2014 5:30 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	16,538,768	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	6,574,117	0	0	0	4.00
5.00	Other receivable	353,827	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	5,130,389	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)	28,597,101	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	205,783	0	0	0	12.00
13.00	Land improvements	443,093	0	0	0	13.00
14.00	Accumulated depreciation	-228,025	0	0	0	14.00
15.00	Buildings	60,655,955	0	0	0	15.00
16.00	Accumulated depreciation	-28,805,369	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	31,522,833	0	0	0	23.00
24.00	Accumulated depreciation	-25,294,356	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	38,499,914	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	16,891,397	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	16,891,397	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	83,988,412	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	2,098,451	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,635,460	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,521,069	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,254,980	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	22,251,486	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	22,251,486	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	31,506,466	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	52,481,946				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)	52,481,946	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	83,988,412	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150072

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

Worksheet G-1

Date/Time Prepared:  
5/27/2014 5:30 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		48,904,755		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		3,577,191			2.00
3.00	Total (sum of line 1 and line 2)		52,481,946		0	3.00
4.00	Additions (credit adjustments) (specify)	0		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)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		52,481,946		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)		52,481,946		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150072

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/27/2014 5:30 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	9,445,684		9,445,684	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	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)	9,445,684		9,445,684	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	1,041,110		1,041,110	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)	1,041,110		1,041,110	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	10,486,794		10,486,794	17.00
18.00	Ancillary services	20,360,437	80,379,842	100,740,279	18.00
19.00	Outpatient services	1,311,560	12,650,893	13,962,453	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PRACTICES	952	17,306,678	17,307,630	27.00
27.01	PHYSICIAN PROFESSIONAL FEES	0	5,014,027	5,014,027	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	32,159,743	115,351,440	147,511,183	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		57,292,023		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		57,292,023		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150072

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

Worksheet G-3

Date/Time Prepared:  
5/27/2014 5:30 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	147,511,183	1.00
2.00	Less contractual allowances and discounts on patients' accounts	89,735,581	2.00
3.00	Net patient revenues (line 1 minus line 2)	57,775,602	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	57,292,023	4.00
5.00	Net income from service to patients (line 3 minus line 4)	483,579	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	2,746,810	24.00
24.01	INVESTMENT INCOME	38,481	24.01
24.02	GAIN ON SALE OF EQUIPMENT	6,344	24.02
24.03	OTHER	301,977	24.03
25.00	Total other income (sum of lines 6-24)	3,093,612	25.00
26.00	Total (line 5 plus line 25)	3,577,191	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)	3,577,191	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150072	Period: From 01/01/2013 To 12/31/2013	Worksheet L Parts I-III Date/Time Prepared: 5/27/2014 5:30 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		324,443	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		3,548	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)		15.09	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)		327,991	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00