

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: 150035	Period: From 01/01/2013 To 12/31/2013	Worksheet S Parts I-III Date/Time Prepared: 5/30/2014 3:36 pm
--	----------------------	---	--

<b>PART I - COST REPORT STATUS</b>			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/30/2014	Time: 3:36 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**  
 MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PORTER MEMORIAL HOSPITAL ( 150035 ) for the cost reporting period beginning 01/01/2013 and ending 12/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

\_\_\_\_\_ Title

\_\_\_\_\_ Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	-235,762	-3,839	124,766	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	55,822	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	-179,940	-3,839	124,766	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 150035		Period: From 01/01/2013 To 12/31/2013		Worksheet S-2 Part I Date/Time Prepared: 5/28/2014 3:12 pm				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 85 EAST US HIGHWAY 6			PO Box:						1.00		
2.00	City: VALPARAISO			State: IN		Zip Code: 46383		County: PORTER		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		PORTER MEMORIAL HOSPITAL		150035	23844	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF		PORTER REHAB UNIT		15T035	23844	5	01/01/2009	N	P	O	5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:		To:			
							1.00		2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2013		12/31/2013		20.00	
21.00	Type of Control (see instructions)						4				21.00	
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						Y		N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)										22.01	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3		N		23.00	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days			
				1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			624	3,467	0	34	4,721	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.			16	219	0	0	35			25.00	
							Urban/Rural S		Date of Geogr			
							1.00		2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.								1		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.								1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.								0		35.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150035	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/28/2014 3:12 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					39.00
		V 1.00	XVIII 2.00	XIX 3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	Y				60.00
		Y/N 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	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/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06
		Program Name 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150035	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/28/2014 3:12 pm		
	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
	1.00	2.00	3.00	4.00		
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.		0.00	0.00	61.20	
				1.00		
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)			0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)			0.00	62.01	
<u>Teaching Hospitals that Claim Residents in Non-Provider Settings</u>						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)			N	63.00	
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
<u>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.</u>						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovi der Site	Unweighted 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
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
<u>Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010</u>						
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150035		Period: From 01/01/2013 To 12/31/2013		Worksheet S-2 Part I Date/Time Prepared: 5/28/2014 3:12 pm	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
<b>Inpatient Psychiatric Facility PPS</b>							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			N		0	76.00
					1.00		
<b>Long Term Care Hospital PPS</b>							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N	80.00
<b>TEFRA Providers</b>							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00
					V	XIX	
					1.00	2.00	
<b>Title V and XIX Services</b>							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N		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
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	97.00
<b>Rural Providers</b>							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			N			106.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150035	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/28/2014 3:12 pm		
		V	XIX			
		1.00	2.00			
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00
		1.00	2.00	3.00		
<b>Miscellaneous Cost Reporting Information</b>						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	28,451	451,960			0 118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00
<b>Transplant Center Information</b>						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				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
<b>All Providers</b>						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		449008		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150035	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/28/2014 3:12 pm			
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: CHS/COMMUNITY HEALTH SYSTEMS INC	Contractor's Name: WISCONSIN PHYSICIAN SERVICES		Contractor's Number: 52280			
142.00	Street: 4000 MERIDIAN BLVD	PO Box:					
143.00	City: FRANKLIN	State: TN		Zip Code: 37067			
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?				Y	144.00	
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.				Y	145.00	
				1.00			
				2.00			
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N	146.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N	149.00	
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
				1.00			
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00
				1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.				Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					1.00	
				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)			04/01/2013	06/29/2013		170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150035	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/28/2014 3:12 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)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			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?	Y		Y	6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			Y	15.00
		Part A		Part B	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/21/2014	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: 150035

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

Worksheet S-2  
Part II  
Date/Time Prepared:  
5/28/2014 3:12 pm

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
<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.			Y	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.			Y	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.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			Y	35.00
				1.00	
				2.00	
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	12/31/2012
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.	CHARLIE	CANON		41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-2686	CHARLES_CANON@CHS.NET		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)	04/21/2014		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.	REVENUE 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: 150035

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/28/2014 3:12 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	192	70,080	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)		192	70,080	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	32	11,680	0.00	0	8.00
8.01 NEONATAL INTENSIVE CARE UNIT	31.01	14	5,110	0.00	0	8.01
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)		238	86,870	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	11	4,015		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		249				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: 150035

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/28/2014 3:12 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)	22,580	3,148	44,387			1.00
2.00 HMO and other (see instructions)	4,623	4,721				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	35				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)	22,580	3,148	44,387			7.00
8.00 INTENSIVE CARE UNIT	3,793	243	6,980			8.00
8.01 NEONATAL INTENSIVE CARE UNIT	0	502	4,008			8.01
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		232	1,295			13.00
14.00 Total (see instructions)	26,373	4,125	56,670	0.00	1,509.61	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	1,969	235	3,228	0.00	14.89	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	1,524.50	27.00
28.00 Observation Bed Days		0	3,014			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: 150035

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/28/2014 3:12 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	5,325	1,240	12,976	1.00
2.00	HMO and other (see instructions)			944			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
8.01	NEONATAL INTENSIVE CARE UNIT						8.01
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	5,325	1,240	12,976	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	163	10	274	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 150035		Period: From 01/01/2013 To 12/31/2013		Worksheet S-3 Part II Date/Time Prepared: 5/28/2014 3:12 pm	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
<b>PART II - WAGE DATA</b>								
<b>SALARIES</b>								
1.00	Total salaries (see instructions)	200.00	82,856,312	0	82,856,312	3,170,963.00	26.13	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		219,346	0	219,346	1,488.00	147.41	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,004,615	321,987	1,326,602	42,127.00	31.49	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>								
11.00	Contract labor (see instructions)		4,557,613	0	4,557,613	75,684.00	60.22	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract Labor: Physician-Part A - Administrative		347,938	0	347,938	3,228.90	107.76	13.00
14.00	Home office salaries & wage-related costs		5,451,374	0	5,451,374	93,779.00	58.13	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
<b>WAGE-RELATED COSTS</b>								
17.00	Wage-related costs (core) (see instructions)		17,508,289	0	17,508,289			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		266,485	0	266,485			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		18,787	0	18,787			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FOHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26.00	Employee Benefits Department	4.00	599,639	0	599,639	18,997.00	31.56	26.00
27.00	Administrative & General	5.00	10,987,547	-755,631	10,231,916	451,416.04	22.67	27.00
28.00	Administrative & General under contract (see inst.)		225,656	0	225,656	5,681.88	39.72	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,836,623	0	1,836,623	75,773.00	24.24	30.00
31.00	Laundry & Linen Service	8.00	118,762	0	118,762	8,947.00	13.27	31.00
32.00	Housekeeping	9.00	2,058,134	0	2,058,134	175,814.00	11.71	32.00
33.00	Housekeeping under contract (see instructions)		311,682	0	311,682	6,288.00	49.57	33.00
34.00	Dietary	10.00	2,111,729	-1,291,288	820,441	56,039.16	14.64	34.00
35.00	Dietary under contract (see instructions)		291,668	0	291,668	8,112.00	35.96	35.00
36.00	Cafeteria	11.00	0	1,291,288	1,291,288	88,199.84	14.64	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	3,114,224	433,644	3,547,868	89,697.00	39.55	38.00
39.00	Central Services and Supply	14.00	891,385	0	891,385	66,296.00	13.45	39.00
40.00	Pharmacy	15.00	3,002,585	0	3,002,585	70,262.00	42.73	40.00
41.00	Medical Records & Medical Records Library	16.00	1,672,687	0	1,672,687	82,097.00	20.37	41.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150035

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/28/2014 3:12 pm

		Worksheet A Line Number	Amount Reported	Reclassifi- 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	
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150035

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/28/2014 3:12 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)	83,685,318	0	83,685,318	3,191,044.88	26.23	1.00
2.00	Excluded area salaries (see instructions)	1,004,615	321,987	1,326,602	42,127.00	31.49	2.00
3.00	Subtotal salaries (line 1 minus line 2)	82,680,703	-321,987	82,358,716	3,148,917.88	26.15	3.00
4.00	Subtotal other wages & related costs (see inst.)	10,356,925	0	10,356,925	172,691.90	59.97	4.00
5.00	Subtotal wage-related costs (see inst.)	17,527,076	0	17,527,076	0.00	21.28	5.00
6.00	Total (sum of lines 3 thru 5)	110,564,704	-321,987	110,242,717	3,321,609.78	33.19	6.00
7.00	Total overhead cost (see instructions)	27,222,321	-321,987	26,900,334	1,203,619.92	22.35	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 150035	Period: From 01/01/2013 To 12/31/2013	Worksheet S-3 Part IV Date/Time Prepared: 5/28/2014 3:12 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	1,996,199	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
5.00	401K/TSA Plan Administration Fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
<b>HEALTH AND INSURANCE COST</b>			
8.00	Health Insurance (Purchased or Self Funded)	7,611,639	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	406,733	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	64,587	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)	275,055	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,000,625	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	4,765,638	17.00
18.00	Medicare Taxes - Employers Portion Only	1,114,544	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	334,108	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	224,433	23.00
24.00	<b>Total Wage Related cost (Sum of lines 1 -23)</b>	<b>17,793,561</b>	<b>24.00</b>
<b>Part B - Other than Core Related Cost</b>			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150035

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

Worksheet S-3  
Part V  
Date/Time Prepared:  
5/28/2014 3:12 pm

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150035	Period: From 01/01/2013 To 12/31/2013	Worksheet S-10 Date/Time Prepared: 5/28/2014 3:12 pm
---	----------------------	---	--

				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)		0.175466		1.00
<b>Medicaid (see instructions for each line)</b>					
2.00	Net revenue from Medicaid		14,851,607		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		114,056,212		6.00
7.00	Medicaid cost (line 1 times line 6)		20,012,987		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)		5,161,380		8.00
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>					
9.00	Net revenue from stand-alone SCHIP		656		9.00
10.00	Stand-alone SCHIP charges		5,733		10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		1,006		11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		350		12.00
<b>Other state or local government indigent care program (see instructions for each line)</b>					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		949,991		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		7,255,363		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		1,273,070		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)		323,079		16.00
<b>Uncompensated care (see instructions for each line)</b>					
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)		5,484,809		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	Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	3,188,036	1,430,378	4,618,414	20.00
22.00	Partial payment by patients approved for charity care	559,392	250,983	810,375	21.00
23.00	Cost of charity care (line 21 minus line 22)	0	0	0	22.00
		559,392	250,983	810,375	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)		22,218,578		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		389,718		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		21,828,860		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		3,830,223		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		4,640,598		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		10,125,407		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150035

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

Worksheet A  
Date/Time Prepared:  
5/28/2014 3:12 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		4,523,236	4,523,236	3,044,399	7,567,635	1.00
2.00	00200		12,331,665	12,331,665	2,363,561	14,695,226	2.00
4.00	00400		626,538	1,226,177	11,491,478	12,717,655	4.00
5.00	00500	599,639					
5.00	00500	10,987,547	95,136,805	106,124,352	-17,220,391	88,903,961	5.00
7.00	00700	1,836,623	7,236,481	9,073,104	-10,239	9,062,865	7.00
8.00	00800	118,762	1,534,510	1,653,272	0	1,653,272	8.00
9.00	00900	2,058,134	1,446,215	3,504,349	0	3,504,349	9.00
10.00	01000	2,111,729	1,024,293	3,136,022	-1,919,602	1,216,420	10.00
11.00	01100	0	0	0	1,914,517	1,914,517	11.00
13.00	01300	3,114,224	826,581	3,940,805	431,573	4,372,378	13.00
14.00	01400	891,385	27,654,797	28,546,182	-27,011,051	1,535,131	14.00
15.00	01500	3,002,585	14,887,107	17,889,692	-14,394,197	3,495,495	15.00
16.00	01600	1,672,687	1,318,495	2,991,182	-56	2,991,126	16.00
23.00	02300	0	0	0	59,458	59,458	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	14,582,415	4,503,195	19,085,610	-740,519	18,345,091	30.00
31.00	03100	5,422,554	1,466,830	6,889,384	-12,342	6,877,042	31.00
31.01	03101	1,637,357	505,212	2,142,569	0	2,142,569	31.01
41.00	04100	950,253	1,015,766	1,966,019	-745,543	1,220,476	41.00
43.00	04300	0	78,922	78,922	221,789	300,711	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	6,537,903	5,391,560	11,929,463	2,402,739	14,332,202	50.00
51.00	05100	1,860,060	331,514	2,191,574	-2,191,574	0	51.00
52.00	05200	1,529,698	413,472	1,943,170	472,435	2,415,605	52.00
53.00	05300	0	1,267,109	1,267,109	-70,609	1,196,500	53.00
54.00	05400	4,146,836	1,634,985	5,781,821	2,957,485	8,739,306	54.00
54.01	05401	460,374	111,426	571,800	-571,800	0	54.01
56.00	05600	437,279	919,518	1,356,797	-1,334,122	22,675	56.00
57.00	05700	534,157	239,386	773,543	-773,543	0	57.00
58.00	05800	245,066	47,330	292,396	-292,396	0	58.00
60.00	06000	4,542,270	7,349,073	11,891,343	-351,030	11,540,313	60.00
65.00	06500	2,158,163	569,284	2,727,447	-120,481	2,606,966	65.00
66.00	06600	0	1,412,629	1,412,629	1,677,836	3,090,465	66.00
67.00	06700	0	692,509	692,509	-692,509	0	67.00
68.00	06800	0	248,945	248,945	-248,945	0	68.00
69.00	06900	3,933,485	1,262,432	5,195,917	365,348	5,561,265	69.00
71.00	07100	0	0	0	1,916,010	1,916,010	71.00
72.00	07200	0	0	0	24,396,830	24,396,830	72.00
73.00	07300	83,145	490,643	573,788	14,182,168	14,755,956	73.00
74.00	07400	0	597,115	597,115	0	597,115	74.00
76.00	03020	0	0	0	0	0	76.00
76.01	03025	399,338	81,218	480,556	-480,556	0	76.01
76.03	03026	378,331	705,210	1,083,541	0	1,083,541	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	6,569,951	1,701,436	8,271,387	-59,458	8,211,929	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		82,801,950	201,583,442	284,385,392	-1,343,337	283,042,055	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	5,226	5,226	0	5,226	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	1,343,337	1,343,337	194.01
194.02	07952	54,362	26,754	81,116	0	81,116	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00		82,856,312	201,615,422	284,471,734	0	284,471,734	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150035

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

Worksheet A  
Date/Time Prepared:  
5/28/2014 3:12 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	CAP REL COSTS-BLDG & FIXT	-43,677	7,523,958	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-1,012,214	13,683,012	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-6,658	12,710,997	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-45,001,330	43,902,631	5.00
7.00	00700	OPERATION OF PLANT	-67,709	8,995,156	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,653,272	8.00
9.00	00900	HOUSEKEEPING	0	3,504,349	9.00
10.00	01000	DIETARY	0	1,216,420	10.00
11.00	01100	CAFETERIA	-136,517	1,778,000	11.00
13.00	01300	NURSING ADMINISTRATION	-58,134	4,314,244	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,535,131	14.00
15.00	01500	PHARMACY	0	3,495,495	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,466	2,989,660	16.00
23.00	02300	ALLIED HEALTH	0	59,458	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-1,578,079	16,767,012	30.00
31.00	03100	INTENSIVE CARE UNIT	-6,000	6,871,042	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	-275,400	1,867,169	31.01
41.00	04100	SUBPROVIDER - IRF	-55,064	1,165,412	41.00
43.00	04300	NURSERY	0	300,711	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-425,000	13,907,202	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,415,605	52.00
53.00	05300	ANESTHESIOLOGY	-1,086,500	110,000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-6,570	8,732,736	54.00
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	-22,675	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	-4	11,540,309	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,606,966	65.00
66.00	06600	PHYSICAL THERAPY	0	3,090,465	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	-2,600	5,558,665	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,916,010	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	24,396,830	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-6,348	14,749,608	73.00
74.00	07400	RENAL DIALYSIS	0	597,115	74.00
76.00	03020	OTHER ANCILLARY	0	0	76.00
76.01	03025	SLEEP LAB	0	0	76.01
76.03	03026	WOUND CARE	0	1,083,541	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-161,989	8,049,940	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-49,953,934	233,088,121	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,226	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	194.00
194.01	07951	MARKETING	0	1,343,337	194.01
194.02	07952	SENIOR CIRCLE	0	81,116	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.04
200.00		TOTAL (SUM OF LINES 118-199)	-49,953,934	234,517,800	200.00

RECLASSIFICATIONS

Provider CCN: 150035

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

Worksheet A-6

Date/Time Prepared:  
5/28/2014 3:12 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - EMPLOYEE BENEFITS</b>					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	11,491,478	1.00
	TOTALS		0	11,491,478	
<b>B - OXYGEN COSTS</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	55,765	1.00
2.00	OPERATING ROOM	50.00	0	45	2.00
	TOTALS		0	55,810	
<b>C - RENTAL AND LEASE EXPENSES</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	758,828	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,260,181	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
	TOTALS		0	3,019,009	
<b>D - OTHER CAPITAL COSTS</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	342,173	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,943,398	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	103,380	3.00
	TOTALS		0	2,388,951	
<b>E - MARKETING DEPARTMENT</b>					
1.00	MARKETING	194.01	321,987	1,021,350	1.00
	TOTALS		321,987	1,021,350	
<b>F - CHIEF NURSING OFFICER COST</b>					
1.00	NURSING ADMINISTRATION	13.00	433,644	0	1.00
	TOTALS		433,644	0	
<b>G - MEDICAL SUPPLIES</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,860,245	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	24,396,830	2.00
3.00	OPERATING ROOM	50.00	0	687,532	3.00
	TOTALS		0	26,944,607	
<b>H - COST OF DRUGS/IV SOLUTIONS</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	14,651,976	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	14,651,976	
<b>I - LABOR AND DELIVERY COSTS</b>					
1.00	ADULTS & PEDIATRICS	30.00	0	19,969	1.00
2.00	NURSERY	43.00	248,411	0	2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	465,782	6,653	3.00
	TOTALS		714,193	26,622	
<b>J - PT, OT, AND ST COSTS</b>					
1.00	PHYSICAL THERAPY	66.00	0	941,454	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	941,454	
<b>K - RECOVERY ROOM</b>					
1.00	OPERATING ROOM	50.00	1,860,060	331,514	1.00
	TOTALS		1,860,060	331,514	
<b>L - OTHER RADIOLOGY COST</b>					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	1,676,876	1,280,609	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	TOTALS		1,676,876	1,280,609	
<b>M - DIETARY COSTS TO CAFETERIA</b>					
1.00	CAFETERIA	11.00	1,291,288	623,229	1.00
	TOTALS		1,291,288	623,229	

Provider CCN: 150035

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

Worksheet A-6  
Date/Time Prepared:  
5/28/2014 3:12 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
N - REHAB THERAPY COSTS					
1.00	PHYSICAL THERAPY	66.00	0	736,382	1.00
	TOTALS		0	736,382	
O - SLEEP LAB COSTS TO EKG					
1.00	ELECTROCARDIOLOGY	69.00	399,338	77,300	1.00
	TOTALS		399,338	77,300	
P - PARAMEDICAL EDUCATION					
1.00	ALLIED HEALTH	23.00	0	59,458	1.00
	TOTALS		0	59,458	
500.00	Grand Total: Increases		6,697,386	63,649,749	500.00

RECLASSIFICATIONS

Provider CCN: 150035

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

Worksheet A-6  
Date/Time Prepared:  
5/28/2014 3:12 pm

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
<b>A - EMPLOYEE BENEFITS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	11,491,478	0		1.00
	TOTALS		0	11,491,478			
<b>B - OXYGEN COSTS</b>							
1.00	RESPIRATORY THERAPY	65.00	0	55,810	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	55,810			
<b>C - RENTAL AND LEASE EXPENSES</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,562,981	10		1.00
2.00	OPERATION OF PLANT	7.00	0	10,239	10		2.00
3.00	DIETARY	10.00	0	5,085	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	2,071	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	75,734	0		5.00
6.00	PHARMACY	15.00	0	252,170	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	56	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	46,295	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	12,342	0		9.00
10.00	SUBPROVIDER - IRF	41.00	0	9,161	0		10.00
11.00	OPERATING ROOM	50.00	0	476,412	0		11.00
12.00	ULTRASOUND	54.01	0	14,376	0		12.00
13.00	LABORATORY	60.00	0	351,030	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	64,671	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	102,000	0		15.00
16.00	DRUGS CHARGED TO PATIENTS	73.00	0	30,468	0		16.00
17.00	SLEEP LAB	76.01	0	3,918	10		17.00
	TOTALS		0	3,019,009			
<b>D - OTHER CAPITAL COSTS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,388,951	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	2,388,951			
<b>E - MARKETING DEPARTMENT</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	321,987	1,021,350	0		1.00
	TOTALS		321,987	1,021,350			
<b>F - CHIEF NURSING OFFICER COST</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	433,644	0	0		1.00
	TOTALS		433,644	0			
<b>G - MEDICAL SUPPLIES</b>							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	26,935,317	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	9,290	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	26,944,607			
<b>H - COST OF DRUGS/IV SOLUTIONS</b>							
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	439,340	0		1.00
2.00	PHARMACY	15.00	0	14,142,027	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	70,609	0		3.00
	TOTALS		0	14,651,976			
<b>I - LABOR AND DELIVERY COSTS</b>							
1.00	ADULTS & PEDIATRICS	30.00	714,193	0	0		1.00
2.00	NURSERY	43.00	0	26,622	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		714,193	26,622			
<b>J - PT, OT, AND ST COSTS</b>							
1.00	OCCUPATIONAL THERAPY	67.00	0	692,509	0		1.00
2.00	SPEECH PATHOLOGY	68.00	0	248,945	0		2.00
	TOTALS		0	941,454			
<b>K - RECOVERY ROOM</b>							
1.00	RECOVERY ROOM	51.00	1,860,060	331,514	0		1.00
	TOTALS		1,860,060	331,514			
<b>L - OTHER RADIOLOGY COST</b>							
1.00	ULTRASOUND	54.01	460,374	97,050	0		1.00
2.00	RADIOISOTOPE	56.00	437,279	896,843	0		2.00
3.00	CT SCAN	57.00	534,157	239,386	0		3.00
4.00	MRI	58.00	245,066	47,330	0		4.00
	TOTALS		1,676,876	1,280,609			
<b>M - DIETARY COSTS TO CAFETERIA</b>							
1.00	DIETARY	10.00	1,291,288	623,229	0		1.00
	TOTALS		1,291,288	623,229			
<b>N - REHAB THERAPY COSTS</b>							
1.00	SUBPROVIDER - IRF	41.00	0	736,382	0		1.00
	TOTALS		0	736,382			

Provider CCN: 150035

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

Worksheet A-6  
Date/Time Prepared:  
5/28/2014 3:12 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	O - SLEEP LAB COSTS TO EKG					
1.00	SLEEP LAB	76.01	399,338	77,300	0	1.00
	TOTALS		399,338	77,300		
	P - PARAMEDICAL EDUCATION					
1.00	EMERGENCY	91.00	0	59,458	0	1.00
	TOTALS		0	59,458		
500.00	Grand Total: Decreases		6,697,386	63,649,749		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150035

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/28/2014 3:12 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	9,133,669	0	0	0	1.00
2.00	Land Improvements	3,459,122	32,294	0	32,294	2.00
3.00	Buildings and Fixtures	247,792,600	429,395	0	429,395	3.00
4.00	Building Improvements	19,182,383	241,470	0	241,470	4.00
5.00	Fixed Equipment	31,342,066	348,544	0	348,544	5.00
6.00	Movable Equipment	139,623,671	5,628,677	0	5,628,677	6.00
7.00	HIT designated Assets	3,089,291	6,103,320	0	6,103,320	7.00
8.00	Subtotal (sum of lines 1-7)	453,622,802	12,783,700	0	12,783,700	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	453,622,802	12,783,700	0	12,783,700	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	9,133,669	0			1.00
2.00	Land Improvements	3,491,416	0			2.00
3.00	Buildings and Fixtures	248,221,995	0			3.00
4.00	Building Improvements	19,351,838	0			4.00
5.00	Fixed Equipment	31,678,590	0			5.00
6.00	Movable Equipment	144,971,162	0			6.00
7.00	HIT designated Assets	8,564,787	0			7.00
8.00	Subtotal (sum of lines 1-7)	465,413,457	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	465,413,457	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150035

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/28/2014 3:12 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	4,523,236	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,628,829	656,856	0	0	45,980	2.00
3.00	Total (sum of lines 1-2)	16,152,065	656,856	0	0	45,980	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	4,523,236				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	12,331,665				2.00
3.00	Total (sum of lines 1-2)	0	16,854,901				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150035

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/28/2014 3:12 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	280,198,918	0	280,198,918	0.602043	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	185,214,541	0	185,214,541	0.397957	0	2.00
3.00	Total (sum of lines 1-2)	465,413,459	0	465,413,459	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	3,727,727	758,828	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	10,616,615	2,917,037	2.00
3.00	Total (sum of lines 1-2)	0	0	0	14,344,342	3,675,865	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	751,832	342,173	1,943,398	0	7,523,958	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	103,380	45,980	0	13,683,012	2.00
3.00	Total (sum of lines 1-2)	751,832	445,553	1,989,378	0	21,206,970	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	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)			0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-111,219		ADMINISTRATIVE & GENERAL	5.00		0	7.00
8.00 Television and radio service (chapter 21)	A	-67,709		OPERATION OF PLANT	7.00		0	8.00
9.00 Parking lot (chapter 21)			0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-3,678,545					0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	B	-6,570		RADIOLOGY-DIAGNOSTIC	54.00		0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-15,910,809					0	12.00
13.00 Laundry and linen service			0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-136,517		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	B	-6,348		DRUGS CHARGED TO PATIENTS	73.00		0	17.00
18.00 Sale of medical records and abstracts	B	-1,466		MEDICAL RECORDS & LIBRARY	16.00		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00		0	19.00
20.00 Vending machines			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			RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3			PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	A	-965,515		CAP REL COSTS-BLDG & FIXT	1.00		9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-1,569,315		CAP REL COSTS-MVBLE EQUIP	2.00		9	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			OCCUPATIONAL THERAPY	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)				ADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3			SPEECH PATHOLOGY	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00		0	32.00
33.00 TRAINING REVENUE	B	-32,316		NURSING ADMINISTRATION	13.00		0	33.00
33.01 MISC. NON PATIENT REVENUE	B	-155,908		ADMINISTRATIVE & GENERAL	5.00		0	33.01

Provider CCN: 150035  
 Period: From 01/01/2013 To 12/31/2013  
 Worksheet A-8  
 Date/Time Prepared: 5/28/2014 3:12 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
33.02 HOSPITAL BAD DEBT	A	-22,218,578	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03 PATIENT PHONES WAGE COSTS	A	-31,005	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04 PATIENT PHONES BENEFITS COSTS	A	-6,658	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05 PATIENT TV DEPRECIATION	A	-81,437	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.05
33.06 MARKETING	A	-944,988	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07 PHYSICIAN RECRUITING	A	-291,163	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08 LOBBYING EXPENSE IN ASSOCIATION DUES	A	-15,790	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09 CHARITABLE CONTRIBUTIONS	A	-104,711	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10 COUNTRY CLUB DUES	A	-8,280	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11 MINORITY INTEREST	A	-3,586,159	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12 PATIENT PHONE DEPRECIATION	A	-105	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.12
33.13 PENALTIES	A	-22,823	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14		0		0.00	0	33.14
33.15		0		0.00	0	33.15
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-49,953,934				50.00

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

Provider CCN: 150035

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

Worksheet A-8-1

Date/Time Prepared: 5/28/2014 3:12 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	DIRECT ALLOCATION - CAPITAL	751,832	0
2.00	5.00	ADMINISTRATIVE & GENERAL	PASI OPERATING COSTS	713,618	0
3.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS	59,678	0
4.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	110,328	0
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	638,643	0
4.02	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL HOME OFFICE COST	5,252,388	0
4.03	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	480,411	1,509,259
4.04	5.00	ADMINISTRATIVE & GENERAL	CIG LEASED EQUIPMENT	643,271	702,837
4.05	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	0	15,772,494
4.06	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	3,048,233
4.07	5.00	ADMINISTRATIVE & GENERAL	401K FEES	0	5,296
4.08	5.00	ADMINISTRATIVE & GENERAL	AUDIT FEES	0	103,147
4.09	5.00	ADMINISTRATIVE & GENERAL	MIS FEES	0	1,389,810
4.10	5.00	ADMINISTRATIVE & GENERAL	MANAGED CARE	0	105,133
4.11	5.00	ADMINISTRATIVE & GENERAL	CASE MANAGEMENT	0	278,044
4.12	5.00	ADMINISTRATIVE & GENERAL	PURCHASE & ANCILLARY	0	20,383
4.13	5.00	ADMINISTRATIVE & GENERAL	EMERGENCY ROOM	0	151,850
4.14	5.00	ADMINISTRATIVE & GENERAL	PPSI FEES	0	19,648
4.15	5.00	ADMINISTRATIVE & GENERAL	COMPLIANCE/HIM/CCA FEES	0	84,563
4.16	5.00	ADMINISTRATIVE & GENERAL	SENIOR CIRCLE	0	45,398
4.17	5.00	ADMINISTRATIVE & GENERAL	PASI COLLECTION FEES	0	1,075,870
4.18	5.00	ADMINISTRATIVE & GENERAL	PASI LIEN UNIT COLLECTION FE	0	240,673
4.19	5.00	ADMINISTRATIVE & GENERAL	EBOS FEES	0	8,340
4.20	0.00			0	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			8,650,169	24,560,978

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

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

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

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

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

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

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



PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150035

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

Worksheet A-8-2

Date/Time Prepared:  
5/28/2014 3:12 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	13.00	DR. A	65,000	0	65,000	159,800	510	1.00
2.00	30.00	DR. B	1,578,079	1,578,079	0	130,900	0	2.00
3.00	31.01	DR. C	275,400	275,400	0	150,200	0	3.00
4.00	50.00	DR. D	425,000	425,000	0	182,900	0	4.00
5.00	53.00	DR. E	1,086,500	1,086,500	0	167,500	0	5.00
6.00	56.00	DR. F	22,675	22,675	0	217,600	0	6.00
7.00	60.00	DR. G	4	4	0	159,800	0	7.00
8.00	69.00	DR. H	2,600	2,600	0	150,200	0	8.00
9.00	91.00	DR. I	161,989	161,989	0	159,800	0	9.00
10.00	5.00	DR. J	39,416	39,416	0	159,800	0	10.00
11.00	41.00	SUBPROVIDER - IRF	55,064	55,064	0	159,800	0	11.00
12.00	31.00	INTENSIVE CARE UNIT	6,000	6,000	0	159,800	0	12.00
200.00			3,717,727	3,652,727	65,000		510	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	13.00	DR. A	39,182	1,959	0	0	0	1.00
2.00	30.00	DR. B	0	0	0	0	0	2.00
3.00	31.01	DR. C	0	0	0	0	0	3.00
4.00	50.00	DR. D	0	0	0	0	0	4.00
5.00	53.00	DR. E	0	0	0	0	0	5.00
6.00	56.00	DR. F	0	0	0	0	0	6.00
7.00	60.00	DR. G	0	0	0	0	0	7.00
8.00	69.00	DR. H	0	0	0	0	0	8.00
9.00	91.00	DR. I	0	0	0	0	0	9.00
10.00	5.00	DR. J	0	0	0	0	0	10.00
11.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	11.00
12.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	12.00
200.00			39,182	1,959	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	13.00	DR. A	0	39,182	25,818	25,818		1.00
2.00	30.00	DR. B	0	0	0	1,578,079		2.00
3.00	31.01	DR. C	0	0	0	275,400		3.00
4.00	50.00	DR. D	0	0	0	425,000		4.00
5.00	53.00	DR. E	0	0	0	1,086,500		5.00
6.00	56.00	DR. F	0	0	0	22,675		6.00
7.00	60.00	DR. G	0	0	0	4		7.00
8.00	69.00	DR. H	0	0	0	2,600		8.00
9.00	91.00	DR. I	0	0	0	161,989		9.00
10.00	5.00	DR. J	0	0	0	39,416		10.00
11.00	41.00	SUBPROVIDER - IRF	0	0	0	55,064		11.00
12.00	31.00	INTENSIVE CARE UNIT	0	0	0	6,000		12.00
200.00			0	39,182	25,818	3,678,545		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150035

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/28/2014 3:12 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal		
		BLDG & FIXT	MVBLE EQUIP				
		1.00	2.00				4.00
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	CAP REL COSTS-BLDG & FIXT	7,523,958	7,523,958			1.00	
2.00 00200	CAP REL COSTS-MVBLE EQUIP	13,683,012		13,683,012		2.00	
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	12,710,997	26,017	54,672	12,791,686	4.00	
5.00 00500	ADMINISTRATIVE & GENERAL	43,902,631	363,797	764,487	1,591,155	5.00	
7.00 00700	OPERATION OF PLANT	8,995,156	1,611,325	3,386,057	285,611	7.00	
8.00 00800	LAUNDRY & LINEN SERVICE	1,653,272	9,371	19,693	18,469	8.00	
9.00 00900	HOUSEKEEPING	3,504,349	62,458	131,250	320,058	9.00	
10.00 01000	DIETARY	1,216,420	189,617	398,463	127,586	10.00	
11.00 01100	CAFETERIA	1,778,000	0	0	200,807	11.00	
13.00 01300	NURSING ADMINISTRATION	4,314,244	94,199	197,951	551,725	13.00	
14.00 01400	CENTRAL SERVICES & SUPPLY	1,535,131	132,112	277,623	138,618	14.00	
15.00 01500	PHARMACY	3,495,495	72,473	152,295	466,929	15.00	
16.00 01600	MEDICAL RECORDS & LIBRARY	2,989,660	25,724	54,057	260,118	16.00	
23.00 02300	ALLIED HEALTH	59,458	0	0	0	23.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	16,767,012	1,086,368	2,282,906	2,156,665	30.00	
31.00 03100	INTENSIVE CARE UNIT	6,871,042	192,922	405,409	843,256	31.00	
31.01 03101	NEONATAL INTENSIVE CARE UNIT	1,867,169	73,467	154,385	254,624	31.01	
41.00 04100	SUBPROVIDER - IRF	1,165,412	120,186	252,561	147,773	41.00	
43.00 04300	NURSERY	300,711	23,296	48,955	38,630	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	13,907,202	638,875	1,342,539	1,305,959	50.00	
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00	
52.00 05200	DELIVERY ROOM & LABOR ROOM	2,415,605	127,159	267,213	310,315	52.00	
53.00 05300	ANESTHESIOLOGY	110,000	11,029	23,176	0	53.00	
54.00 05400	RADIOLOGY-DIAGNOSTIC	8,732,736	455,314	956,802	905,640	54.00	
54.01 05401	ULTRASOUND	0	0	0	0	54.01	
56.00 05600	RADIO SOTOPE	0	0	0	0	56.00	
57.00 05700	CT SCAN	0	0	0	0	57.00	
58.00 05800	MRI	0	0	0	0	58.00	
60.00 06000	LABORATORY	11,540,309	173,283	364,139	706,364	60.00	
65.00 06500	RESPIRATORY THERAPY	2,606,966	36,090	75,840	335,614	65.00	
66.00 06600	PHYSICAL THERAPY	3,090,465	176,511	370,922	0	66.00	
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00	
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00	
69.00 06900	ELECTROCARDIOLOGY	5,558,665	296,560	623,196	673,793	69.00	
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,916,010	0	0	0	71.00	
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	24,396,830	0	0	0	72.00	
73.00 07300	DRUGS CHARGED TO PATIENTS	14,749,608	0	0	12,930	73.00	
74.00 07400	RENAL DIALYSIS	597,115	6,416	13,484	0	74.00	
76.00 03020	OTHER ANCILLARY	0	0	0	0	76.00	
76.01 03025	SLEEP LAB	0	0	0	0	76.01	
76.03 03026	WOUND CARE	1,083,541	35,924	75,492	58,834	76.03	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000	CLINIC	0	0	0	0	90.00	
91.00 09100	EMERGENCY	8,049,940	334,864	703,687	1,021,687	91.00	
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00	
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	233,088,121	6,375,357	13,397,254	12,733,160	231,595,236	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,391	19,734	0	29,125	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	5,226	857,911	259,795	0	1,122,932	192.00
192.01 19201	OTHER NONREIMBURSABLE	0	2,964	6,229	0	9,193	192.01
194.00 07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01 07951	MARKETING	1,343,337	0	0	50,072	1,393,409	194.01
194.02 07952	SENIOR CIRCLE	81,116	0	0	8,454	89,570	194.02
194.03 07953	OTHER NONREIMB COST C - REGENCY LTA	0	147,139	0	0	147,139	194.03
194.04 07954	OTHER NONREIMBURSABLE COST CENTERS	0	131,196	0	0	131,196	194.04
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers					0	201.00
202.00	TOTAL (sum lines 118-201)	234,517,800	7,523,958	13,683,012	12,791,686	234,517,800	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150035

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/28/2014 3:12 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	46,622,070				5.00
7.00	00700	OPERATION OF PLANT	3,542,794	17,820,943			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	422,016	31,184	2,154,005		8.00
9.00	00900	HOUSEKEEPING	997,003	207,838	0	5,222,956	9.00
10.00	01000	DIETARY	479,403	630,976	0	187,440	3,229,905
11.00	01100	CAFETERIA	490,995	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,279,869	313,460	0	93,118	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	516,969	439,623	87,973	130,596	14.00
15.00	01500	PHARMACY	1,038,955	241,163	13,327	71,641	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	826,153	85,601	0	25,429	16.00
23.00	02300	ALLIED HEALTH	14,753	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	5,531,483	3,615,043	809,467	1,073,898	1,914,437
31.00	03100	INTENSIVE CARE UNIT	2,062,588	641,976	152,140	190,708	133,954
31.01	03101	NEONATAL INTENSIVE CARE UNIT	583,010	244,473	10,230	72,624	6,922
41.00	04100	SUBPROVIDER - IRF	418,325	399,937	51,010	118,807	142,008
43.00	04300	NURSERY	102,127	77,521	13,881	23,029	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	4,266,438	2,125,946	312,748	631,542	12,300
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	774,229	423,138	61,974	125,699	26,321
53.00	05300	ANESTHESIOLOGY	35,781	36,700	0	10,902	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,741,925	1,515,121	166,015	450,088	1,297
54.01	05401	ULTRASOUND	0	0	0	0	0
56.00	05600	RADIO SOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
60.00	06000	LABORATORY	3,172,079	576,623	448	171,294	0
65.00	06500	RESPIRATORY THERAPY	757,906	120,095	0	35,676	0
66.00	06600	PHYSICAL THERAPY	902,661	587,364	9,967	174,485	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	1,774,657	986,847	128,709	293,157	22,417
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	475,414	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,053,581	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	3,662,984	0	0	0	0
74.00	07400	RENAL DIALYSIS	153,098	21,352	0	6,343	0
76.00	03020	OTHER ANCILLARY	0	0	0	0	0
76.01	03025	SLEEP LAB	0	0	0	0	0
76.03	03026	WOUND CARE	311,099	119,543	24,202	35,512	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	2,508,608	1,114,308	311,914	331,021	31,359
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	45,896,903	14,555,832	2,154,005	4,253,009	2,291,015
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,227	31,249	0	9,283	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	278,630	2,734,370	0	812,283	225,026
192.01	19201	OTHER NONREIMBURSABLE	2,281	9,865	0	2,930	0
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0
194.01	07951	MARKETING	345,742	0	0	0	0
194.02	07952	SENIOR CIRCLE	22,225	0	0	0	0
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	36,509	489,627	0	145,451	713,864
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	32,553	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	46,622,070	17,820,943	2,154,005	5,222,956	3,229,905

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150035

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/28/2014 3:12 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	2,469,802					11.00
13.00	01300		6,941,054				13.00
14.00	01400	71,314	0	3,329,959			14.00
15.00	01500	75,588	398,878	0	6,026,744		15.00
16.00	01600	88,321	0	0	0	4,355,063	16.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	599,046	1,842,320	0	0	338,776	30.00
31.00	03100	177,894	720,359	0	0	89,629	31.00
31.01	03101	51,533	217,515	0	0	51,294	31.01
41.00	04100	33,319	126,236	0	0	21,830	41.00
43.00	04300	9,197	33,000	0	0	4,923	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	312,043	1,115,627	435	0	901,763	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	73,821	265,089	0	0	39,546	52.00
53.00	05300	0	0	0	0	38,302	53.00
54.00	05400	197,138	773,651	0	0	584,786	54.00
54.01	05401	0	0	0	0	0	54.01
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	226,318	0	248,638	0	489,609	60.00
65.00	06500	80,265	0	0	0	48,308	65.00
66.00	06600	0	0	0	0	73,426	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	147,104	575,594	0	0	297,314	69.00
71.00	07100	0	0	259,484	0	98,503	71.00
72.00	07200	0	0	2,821,402	0	470,581	72.00
73.00	07300	1,410	0	0	6,026,744	394,666	73.00
74.00	07400	0	0	0	0	9,797	74.00
76.00	03020	0	0	0	0	0	76.00
76.01	03025	0	0	0	0	0	76.01
76.03	03026	14,769	0	0	0	18,202	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	202,240	872,785	0	0	383,808	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		2,457,808	6,941,054	3,329,959	6,026,744	4,355,063	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	9,756	0	0	0	0	194.01
194.02	07952	2,238	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		2,469,802	6,941,054	3,329,959	6,026,744	4,355,063	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150035

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/28/2014 3:12 pm

Cost Center Description		ALLIED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		23.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300					13.00
14.00	01400					14.00
15.00	01500					15.00
16.00	01600					16.00
23.00	02300	74,211				23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	0	38,017,421	0	38,017,421	30.00
31.00	03100	0	12,481,877	0	12,481,877	31.00
31.01	03101	0	3,587,246	0	3,587,246	31.01
41.00	04100	0	2,997,404	0	2,997,404	41.00
43.00	04300	0	675,270	0	675,270	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	0	26,873,417	0	26,873,417	50.00
51.00	05100	0	0	0	0	51.00
52.00	05200	0	4,910,109	0	4,910,109	52.00
53.00	05300	0	265,890	0	265,890	53.00
54.00	05400	0	17,480,513	0	17,480,513	54.00
54.01	05401	0	0	0	0	54.01
56.00	05600	0	0	0	0	56.00
57.00	05700	0	0	0	0	57.00
58.00	05800	0	0	0	0	58.00
60.00	06000	0	17,669,104	0	17,669,104	60.00
65.00	06500	0	4,096,760	0	4,096,760	65.00
66.00	06600	0	5,385,801	0	5,385,801	66.00
67.00	06700	0	0	0	0	67.00
68.00	06800	0	0	0	0	68.00
69.00	06900	0	11,378,013	0	11,378,013	69.00
71.00	07100	0	2,749,411	0	2,749,411	71.00
72.00	07200	0	33,742,394	0	33,742,394	72.00
73.00	07300	0	24,848,342	0	24,848,342	73.00
74.00	07400	0	807,605	0	807,605	74.00
76.00	03020	0	0	0	0	76.00
76.01	03025	0	0	0	0	76.01
76.03	03026	0	1,777,118	0	1,777,118	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	0	0	0	0	90.00
91.00	09100	74,211	15,940,432	0	15,940,432	91.00
92.00	09200	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		74,211	225,684,127	0	225,684,127	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	0	76,884	0	76,884	190.00
192.00	19200	0	5,173,241	0	5,173,241	192.00
192.01	19201	0	24,269	0	24,269	192.01
194.00	07950	0	0	0	0	194.00
194.01	07951	0	1,748,907	0	1,748,907	194.01
194.02	07952	0	114,033	0	114,033	194.02
194.03	07953	0	1,532,590	0	1,532,590	194.03
194.04	07954	0	163,749	0	163,749	194.04
200.00		0	0	0	0	200.00
201.00		0	0	0	0	201.00
202.00		74,211	234,517,800	0	234,517,800	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150035

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/28/2014 3:12 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT		
		BLDG & FIXT	MVBLE EQUIP				
		0	1.00				2.00
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	26,017	54,672	80,689	80,689	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	363,797	764,487	1,128,284	10,038	5.00
7.00 00700	OPERATION OF PLANT	0	1,611,325	3,386,057	4,997,382	1,802	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	9,371	19,693	29,064	117	8.00
9.00 00900	HOUSEKEEPING	0	62,458	131,250	193,708	2,019	9.00
10.00 01000	DIETARY	0	189,617	398,463	588,080	805	10.00
11.00 01100	CAFETERIA	0	0	0	0	1,267	11.00
13.00 01300	NURSING ADMINISTRATION	0	94,199	197,951	292,150	3,480	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	132,112	277,623	409,735	874	14.00
15.00 01500	PHARMACY	0	72,473	152,295	224,768	2,946	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	25,724	54,057	79,781	1,641	16.00
23.00 02300	ALLIED HEALTH	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	0	1,086,368	2,282,906	3,369,274	13,599	30.00
31.00 03100	INTENSIVE CARE UNIT	0	192,922	405,409	598,331	5,320	31.00
31.01 03101	NEONATAL INTENSIVE CARE UNIT	0	73,467	154,385	227,852	1,606	31.01
41.00 04100	SUBPROVIDER - IRF	0	120,186	252,561	372,747	932	41.00
43.00 04300	NURSERY	0	23,296	48,955	72,251	244	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	0	638,875	1,342,539	1,981,414	8,238	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	127,159	267,213	394,372	1,958	52.00
53.00 05300	ANESTHESIOLOGY	0	11,029	23,176	34,205	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	455,314	956,802	1,412,116	5,713	54.00
54.01 05401	ULTRASOUND	0	0	0	0	0	54.01
56.00 05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MRI	0	0	0	0	0	58.00
60.00 06000	LABORATORY	0	173,283	364,139	537,422	4,456	60.00
65.00 06500	RESPIRATORY THERAPY	0	36,090	75,840	111,930	2,117	65.00
66.00 06600	PHYSICAL THERAPY	0	176,511	370,922	547,433	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	296,560	623,196	919,756	4,250	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	82	73.00
74.00 07400	RENAL DIALYSIS	0	6,416	13,484	19,900	0	74.00
76.00 03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01 03025	SLEEP LAB	0	0	0	0	0	76.01
76.03 03026	WOUND CARE	0	35,924	75,492	111,416	371	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000	CLINIC	0	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	334,864	703,687	1,038,551	6,445	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	6,375,357	13,397,254	19,772,611	80,320	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,391	19,734	29,125	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	857,911	259,795	1,117,706	0	192.00
192.01 19201	OTHER NONREIMBURSABLE	0	2,964	6,229	9,193	0	192.01
194.00 07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01 07951	MARKETING	0	0	0	0	316	194.01
194.02 07952	SENIOR CIRCLE	0	0	0	0	53	194.02
194.03 07953	OTHER NONREIMB COST C - REGENCY LTA	0	147,139	0	147,139	0	194.03
194.04 07954	OTHER NONREIMBURSABLE COST CENTERS	0	131,196	0	131,196	0	194.04
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	7,523,958	13,683,012	21,206,970	80,689	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150035	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 5/28/2014 3:12 pm				
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	1,138,322				5.00	
7.00	00700	OPERATION OF PLANT	86,497	5,085,681			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	10,303	8,899	48,383		8.00	
9.00	00900	HOUSEKEEPING	24,342	59,312	0	279,381	9.00	
10.00	01000	DIETARY	11,705	180,066	0	10,026	790,682	10.00
11.00	01100	CAFETERIA	11,988	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	31,248	89,454	0	4,981	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,622	125,458	1,976	6,986	0	14.00
15.00	01500	PHARMACY	25,366	68,822	299	3,832	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	20,170	24,429	0	1,360	0	16.00
23.00	02300	ALLIED HEALTH	360	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	135,051	1,031,650	18,182	57,443	468,655	30.00
31.00	03100	INTENSIVE CARE UNIT	50,358	183,205	3,417	10,201	32,792	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	14,234	69,767	230	3,885	1,694	31.01
41.00	04100	SUBPROVIDER - IRF	10,213	114,133	1,146	6,355	34,764	41.00
43.00	04300	NURSERY	2,493	22,123	312	1,232	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	104,165	606,695	7,025	33,782	3,011	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,903	120,754	1,392	6,724	6,443	52.00
53.00	05300	ANESTHESIOLOGY	874	10,473	0	583	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	66,944	432,380	3,729	24,076	317	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	77,446	164,555	10	9,163	0	60.00
65.00	06500	RESPIRATORY THERAPY	18,504	34,272	0	1,908	0	65.00
66.00	06600	PHYSICAL THERAPY	22,038	167,620	224	9,333	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	43,328	281,623	2,891	15,681	5,488	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,607	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	147,847	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	89,431	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	3,738	6,093	0	339	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03025	SLEEP LAB	0	0	0	0	0	76.01
76.03	03026	WOUND CARE	7,595	34,115	544	1,900	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	61,247	317,997	7,006	17,707	7,677	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,120,617	4,153,895	48,383	227,497	560,841	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	176	8,918	0	497	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,803	780,325	0	43,450	55,087	192.00
192.01	19201	OTHER NONREIMBURSABLE	56	2,815	0	157	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	8,441	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	543	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	891	139,728	0	7,780	174,754	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	795	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,138,322	5,085,681	48,383	279,381	790,682	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150035		Period: From 01/01/2013 To 12/31/2013		Worksheet B Part II Date/Time Prepared: 5/28/2014 3:12 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	13,255					11.00
13.00	01300	518	421,831				13.00
14.00	01400	383	0	558,034			14.00
15.00	01500	406	24,240	0	350,679		15.00
16.00	01600	474	0	0	0	127,855	16.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	3,214	111,981	0	0	9,905	30.00
31.00	03100	955	43,776	0	0	2,621	31.00
31.01	03101	277	13,218	0	0	1,500	31.01
41.00	04100	179	7,671	0	0	638	41.00
43.00	04300	49	2,005	0	0	144	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	1,675	67,797	73	0	26,888	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	396	16,110	0	0	1,156	52.00
53.00	05300	0	0	0	0	1,120	53.00
54.00	05400	1,058	47,015	0	0	17,098	54.00
54.01	05401	0	0	0	0	0	54.01
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	1,215	0	41,667	0	14,315	60.00
65.00	06500	431	0	0	0	1,412	65.00
66.00	06600	0	0	0	0	2,147	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	789	34,979	0	0	8,693	69.00
71.00	07100	0	0	43,484	0	2,880	71.00
72.00	07200	0	0	472,810	0	13,759	72.00
73.00	07300	8	0	0	350,679	11,539	73.00
74.00	07400	0	0	0	0	286	74.00
76.00	03020	0	0	0	0	0	76.00
76.01	03025	0	0	0	0	0	76.01
76.03	03026	79	0	0	0	532	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	1,085	53,039	0	0	11,222	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		13,191	421,831	558,034	350,679	127,855	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	52	0	0	0	0	194.01
194.02	07952	12	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		13,255	421,831	558,034	350,679	127,855	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150035	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 5/28/2014 3:12 pm
-------------------------------------	--	----------------------	---	--

Cost Center Description		ALLIED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		23.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				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
23.00	02300	ALLIED HEALTH	360			23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS		5,218,954	0	5,218,954
31.00	03100	INTENSIVE CARE UNIT		930,976	0	930,976
31.01	03101	NEONATAL INTENSIVE CARE UNIT		334,263	0	334,263
41.00	04100	SUBPROVIDER - IRF		548,778	0	548,778
43.00	04300	NURSERY		100,853	0	100,853
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM		2,840,763	0	2,840,763
51.00	05100	RECOVERY ROOM		0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM		568,208	0	568,208
53.00	05300	ANESTHESIOLOGY		47,255	0	47,255
54.00	05400	RADIOLOGY-DIAGNOSTIC		2,010,446	0	2,010,446
54.01	05401	ULTRASOUND		0	0	0
56.00	05600	RADIOISOTOPE		0	0	0
57.00	05700	CT SCAN		0	0	0
58.00	05800	MRI		0	0	0
60.00	06000	LABORATORY		850,249	0	850,249
65.00	06500	RESPIRATORY THERAPY		170,574	0	170,574
66.00	06600	PHYSICAL THERAPY		748,795	0	748,795
67.00	06700	OCCUPATIONAL THERAPY		0	0	0
68.00	06800	SPEECH PATHOLOGY		0	0	0
69.00	06900	ELECTROCARDIOLOGY		1,317,478	0	1,317,478
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		57,971	0	57,971
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		634,416	0	634,416
73.00	07300	DRUGS CHARGED TO PATIENTS		451,739	0	451,739
74.00	07400	RENAL DIALYSIS		30,356	0	30,356
76.00	03020	OTHER ANCILLARY		0	0	0
76.01	03025	SLEEP LAB		0	0	0
76.03	03026	WOUND CARE		156,552	0	156,552
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC		0	0	0
91.00	09100	EMERGENCY		1,521,976	0	1,521,976
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	18,540,602	0	18,540,602
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		38,716	0	38,716
192.00	19200	PHYSICIANS' PRIVATE OFFICES		2,003,371	0	2,003,371
192.01	19201	OTHER NONREIMBURSABLE		12,221	0	12,221
194.00	07950	OTHER NONREIMBURSABLE		0	0	0
194.01	07951	MARKETING		8,809	0	8,809
194.02	07952	SENIOR CIRCLE		608	0	608
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA		470,292	0	470,292
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS		131,991	0	131,991
200.00		Cross Foot Adjustments	360	360	0	360
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	360	21,206,970	0	21,206,970

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150035

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

Worksheet B-1  
Date/Time Prepared:  
5/28/2014 3:12 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	771,575				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		667,732			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,668	2,668	82,256,673		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	37,307	37,307	10,231,916	-46,622,070	5.00
7.00 00700	OPERATION OF PLANT	165,240	165,240	1,836,623	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	961	961	118,762	0	8.00
9.00 00900	HOUSEKEEPING	6,405	6,405	2,058,134	0	9.00
10.00 01000	DIETARY	19,445	19,445	820,441	0	10.00
11.00 01100	CAFETERIA	0	0	1,291,288	0	11.00
13.00 01300	NURSING ADMINISTRATION	9,660	9,660	3,547,868	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	13,548	13,548	891,385	0	14.00
15.00 01500	PHARMACY	7,432	7,432	3,002,585	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,638	2,638	1,672,687	0	16.00
23.00 02300	ALLIED HEALTH	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	111,406	111,406	13,868,222	0	30.00
31.00 03100	INTENSIVE CARE UNIT	19,784	19,784	5,422,554	0	31.00
31.01 03101	NEONATAL INTENSIVE CARE UNIT	7,534	7,534	1,637,357	0	31.01
41.00 04100	SUBPROVIDER - IRF	12,325	12,325	950,253	0	41.00
43.00 04300	NURSERY	2,389	2,389	248,411	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	65,516	65,516	8,397,963	0	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	13,040	13,040	1,995,480	0	52.00
53.00 05300	ANESTHESIOLOGY	1,131	1,131	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	46,692	46,692	5,823,712	0	54.00
54.01 05401	ULTRASOUND	0	0	0	0	54.01
56.00 05600	RADIO SOTOPE	0	0	0	0	56.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MRI	0	0	0	0	58.00
60.00 06000	LABORATORY	17,770	17,770	4,542,270	0	60.00
65.00 06500	RESPIRATORY THERAPY	3,701	3,701	2,158,163	0	65.00
66.00 06600	PHYSICAL THERAPY	18,101	18,101	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	30,412	30,412	4,332,823	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	83,145	0	73.00
74.00 07400	RENAL DIALYSIS	658	658	0	0	74.00
76.00 03020	OTHER ANCILLARY	0	0	0	0	76.00
76.01 03025	SLEEP LAB	0	0	0	0	76.01
76.03 03026	WOUND CARE	3,684	3,684	378,331	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	34,340	34,340	6,569,951	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	653,787	653,787	81,880,324	-46,622,070	184,973,166
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	963	963	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	87,978	12,678	0	0	192.00
192.01 19201	OTHER NONREIMBURSABLE	304	304	0	0	192.01
194.00 07950	OTHER NONREIMBURSABLE	0	0	0	0	194.00
194.01 07951	MARKETING	0	0	321,987	0	194.01
194.02 07952	SENIOR CIRCLE	0	0	54,362	0	194.02
194.03 07953	OTHER NONREIMB COST C - REGENCY LTA	15,089	0	0	0	194.03
194.04 07954	OTHER NONREIMBURSABLE COST CENTERS	13,454	0	0	0	194.04
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	7,523,958	13,683,012	12,791,686	46,622,070	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	9.751428	20.491772	0.155509	0.248127	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			80,689	1,138,322	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000981	0.006058	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150035

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

Worksheet B-1

Date/Time Prepared:  
5/28/2014 3:12 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)		
		7.00	8.00	9.00	10.00	11.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	549,194				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	961	1,913,697			8.00	
9.00	00900	HOUSEKEEPING	6,405	0	541,828		9.00	
10.00	01000	DIETARY	19,445	0	19,445	236,588	10.00	
11.00	01100	CAFETERIA	0	0	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	9,660	0	9,660	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	13,548	78,158	13,548	0	14.00	
15.00	01500	PHARMACY	7,432	11,840	7,432	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	2,638	0	2,638	0	16.00	
23.00	02300	ALLIED HEALTH	0	0	0	0	23.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	111,406	719,160	111,406	140,231	26,771	30.00
31.00	03100	INTENSIVE CARE UNIT	19,784	135,167	19,784	9,812	7,950	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	7,534	9,089	7,534	507	2,303	31.01
41.00	04100	SUBPROVIDER - I RF	12,325	45,319	12,325	10,402	1,489	41.00
43.00	04300	NURSERY	2,389	12,332	2,389	0	411	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	65,516	277,857	65,516	901	13,945	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,040	55,060	13,040	1,928	3,299	52.00
53.00	05300	ANESTHESIOLOGY	1,131	0	1,131	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	46,692	147,494	46,692	95	8,810	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	17,770	398	17,770	0	10,114	60.00
65.00	06500	RESPIRATORY THERAPY	3,701	0	3,701	0	3,587	65.00
66.00	06600	PHYSICAL THERAPY	18,101	8,855	18,101	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	30,412	114,350	30,412	1,642	6,574	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	63	73.00
74.00	07400	RENAL DIALYSIS	658	0	658	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03025	SLEEP LAB	0	0	0	0	0	76.01
76.03	03026	WOUND CARE	3,684	21,502	3,684	0	660	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	34,340	277,116	34,340	2,297	9,038	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	448,572	1,913,697	441,206	167,815	109,838	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	963	0	963	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	84,266	0	84,266	16,483	0	192.00
192.01	19201	OTHER NONREIMBURSABLE	304	0	304	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	436	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	100	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	15,089	0	15,089	52,290	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	17,820,943	2,154,005	5,222,956	3,229,905	2,469,802	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	32.449267	1.125573	9.639509	13.652024	22.376665	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	5,085,681	48,383	279,381	790,682	13,255	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	9.260263	0.025282	0.515627	3.342021	0.120092	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150035

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

Worksheet B-1  
Date/Time Prepared:  
5/28/2014 3:12 pm

Cost Center Description		NURSING ADMINISTRATION (NURSING WAGES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	ALLIED HEALTH (ASSIGNED TIME)	
		13.00	14.00	15.00	16.00	23.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	52,249,311					13.00
14.00	01400		28,243,482				14.00
15.00	01500	3,002,585		15,384,166			15.00
16.00	01600				1,286,201,063		16.00
23.00	02300					100	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	13,868,222	0	0	100,051,970	0	30.00
31.00	03100	5,422,554	0	0	26,470,319	0	31.00
31.01	03101	1,637,357	0	0	15,148,892	0	31.01
41.00	04100	950,253	0	0	6,446,993	0	41.00
43.00	04300	248,411	0	0	1,453,908	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	8,397,963	3,687	0	266,325,113	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	1,995,479	0	0	11,679,202	0	52.00
53.00	05300	0	0	0	11,312,014	0	53.00
54.00	05400	5,823,712	0	0	172,707,054	0	54.00
54.01	05401	0	0	0	0	0	54.01
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	0	2,108,856	0	144,598,170	0	60.00
65.00	06500	0	0	0	14,267,069	0	65.00
66.00	06600	0	0	0	21,685,263	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	4,332,824	0	0	87,806,813	0	69.00
71.00	07100	0	2,200,843	0	29,091,344	0	71.00
72.00	07200	0	23,930,096	0	138,978,393	0	72.00
73.00	07300	0	0	15,384,166	116,558,181	0	73.00
74.00	07400	0	0	0	2,893,386	0	74.00
76.00	03020	0	0	0	0	0	76.00
76.01	03025	0	0	0	0	0	76.01
76.03	03026	0	0	0	5,375,639	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	6,569,951	0	0	113,351,340	100	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		52,249,311	28,243,482	15,384,166	1,286,201,063	100	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
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	0	0	0	0	0	194.04
200.00							200.00
201.00							201.00
202.00		6,941,054	3,329,959	6,026,744	4,355,063	74,211	202.00
203.00		0.132845	0.117902	0.391750	0.003386	742.110000	203.00
204.00		421,831	558,034	350,679	127,855	360	204.00
205.00		0.008073	0.019758	0.022795	0.000099	3.600000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150035

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/28/2014 3:12 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					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	38,017,421		38,017,421	0	38,017,421	30.00
31.00	03100 INTENSIVE CARE UNIT	12,481,877		12,481,877	0	12,481,877	31.00
31.01	03101 NEONATAL INTENSIVE CARE UNIT	3,587,246		3,587,246	0	3,587,246	31.01
41.00	04100 SUBPROVIDER - IRF	2,997,404		2,997,404	0	2,997,404	41.00
43.00	04300 NURSERY	675,270		675,270	0	675,270	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	26,873,417		26,873,417	0	26,873,417	50.00
51.00	05100 RECOVERY ROOM	0		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4,910,109		4,910,109	0	4,910,109	52.00
53.00	05300 ANESTHESIOLOGY	265,890		265,890	0	265,890	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	17,480,513		17,480,513	0	17,480,513	54.00
54.01	05401 ULTRASOUND	0		0	0	0	54.01
56.00	05600 RADIO SOTOPE	0		0	0	0	56.00
57.00	05700 CT SCAN	0		0	0	0	57.00
58.00	05800 MRI	0		0	0	0	58.00
60.00	06000 LABORATORY	17,669,104		17,669,104	0	17,669,104	60.00
65.00	06500 RESPIRATORY THERAPY	4,096,760	0	4,096,760	0	4,096,760	65.00
66.00	06600 PHYSICAL THERAPY	5,385,801	0	5,385,801	0	5,385,801	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	11,378,013		11,378,013	0	11,378,013	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,749,411		2,749,411	0	2,749,411	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	33,742,394		33,742,394	0	33,742,394	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	24,848,342		24,848,342	0	24,848,342	73.00
74.00	07400 RENAL DIALYSIS	807,605		807,605	0	807,605	74.00
76.00	03020 OTHER ANCILLARY	0		0	0	0	76.00
76.01	03025 SLEEP LAB	0		0	0	0	76.01
76.03	03026 WOUND CARE	1,777,118		1,777,118	0	1,777,118	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0		0	0	0	90.00
91.00	09100 EMERGENCY	15,940,432		15,940,432	0	15,940,432	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2,417,349		2,417,349	0	2,417,349	92.00
200.00	Subtotal (see instructions)	228,101,476	0	228,101,476	0	228,101,476	200.00
201.00	Less Observation Beds	2,417,349		2,417,349	0	2,417,349	201.00
202.00	Total (see instructions)	225,684,127	0	225,684,127	0	225,684,127	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150035	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/28/2014 3:12 pm
		Title XVII	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			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	93,251,590		93,251,590			30.00
31.00 03100 INTENSIVE CARE UNIT	26,470,319		26,470,319			31.00
31.01 03101 NEONATAL INTENSIVE CARE UNIT	15,148,892		15,148,892			31.01
41.00 04100 SUBPROVIDER - I RF	6,446,993		6,446,993			41.00
43.00 04300 NURSERY	1,453,908		1,453,908			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	127,308,814	139,016,299	266,325,113	0.100905	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	11,659,350	19,852	11,679,202	0.420415	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	5,463,830	5,848,184	11,312,014	0.023505	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	31,108,883	141,598,171	172,707,054	0.101215	0.000000	54.00
54.01 05401 ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00 05600 RADIOLOGY	0	0	0	0.000000	0.000000	56.00
57.00 05700 CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00 05800 MRI	0	0	0	0.000000	0.000000	58.00
60.00 06000 LABORATORY	57,159,682	87,438,488	144,598,170	0.122195	0.000000	60.00
65.00 06500 RESPIRATORY THERAPY	12,453,391	1,813,678	14,267,069	0.287148	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	14,635,886	7,049,377	21,685,263	0.248362	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	33,393,247	54,413,566	87,806,813	0.129580	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	17,202,132	11,889,212	29,091,344	0.094510	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	90,747,044	48,231,349	138,978,393	0.242789	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	49,990,716	66,567,465	116,558,181	0.213184	0.000000	73.00
74.00 07400 RENAL DIALYSIS	2,810,185	83,201	2,893,386	0.279121	0.000000	74.00
76.00 03020 OTHER ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01 03025 SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.03 03026 WOUND CARE	78,592	5,297,047	5,375,639	0.330587	0.000000	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0	0.000000	0.000000	90.00
91.00 09100 EMERGENCY	30,024,996	83,326,344	113,351,340	0.140629	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	500,000	6,300,380	6,800,380	0.355473	0.000000	92.00
200.00 Subtotal (see instructions)	627,308,450	658,892,613	1,286,201,063			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	627,308,450	658,892,613	1,286,201,063			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150035

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/28/2014 3:12 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
31.01	03101 NEONATAL INTENSIVE CARE UNIT				31.01
41.00	04100 SUBPROVIDER - I RF				41.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.100905			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.420415			52.00
53.00	05300 ANESTHESIOLOGY	0.023505			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.101215			54.00
54.01	05401 ULTRASOUND	0.000000			54.01
56.00	05600 RADIOISOTOPE	0.000000			56.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MRI	0.000000			58.00
60.00	06000 LABORATORY	0.122195			60.00
65.00	06500 RESPIRATORY THERAPY	0.287148			65.00
66.00	06600 PHYSICAL THERAPY	0.248362			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.129580			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.094510			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.242789			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.213184			73.00
74.00	07400 RENAL DIALYSIS	0.279121			74.00
76.00	03020 OTHER ANCILLARY	0.000000			76.00
76.01	03025 SLEEP LAB	0.000000			76.01
76.03	03026 WOUND CARE	0.330587			76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.140629			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.355473			92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150035

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/28/2014 3:12 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					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	38,017,421		38,017,421	0	38,017,421	30.00
31.00	03100 INTENSIVE CARE UNIT	12,481,877		12,481,877	0	12,481,877	31.00
31.01	03101 NEONATAL INTENSIVE CARE UNIT	3,587,246		3,587,246	0	3,587,246	31.01
41.00	04100 SUBPROVIDER - IRF	2,997,404		2,997,404	0	2,997,404	41.00
43.00	04300 NURSERY	675,270		675,270	0	675,270	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	26,873,417		26,873,417	0	26,873,417	50.00
51.00	05100 RECOVERY ROOM	0		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4,910,109		4,910,109	0	4,910,109	52.00
53.00	05300 ANESTHESIOLOGY	265,890		265,890	0	265,890	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	17,480,513		17,480,513	0	17,480,513	54.00
54.01	05401 ULTRASOUND	0		0	0	0	54.01
56.00	05600 RADIO SOTOPE	0		0	0	0	56.00
57.00	05700 CT SCAN	0		0	0	0	57.00
58.00	05800 MRI	0		0	0	0	58.00
60.00	06000 LABORATORY	17,669,104		17,669,104	0	17,669,104	60.00
65.00	06500 RESPIRATORY THERAPY	4,096,760	0	4,096,760	0	4,096,760	65.00
66.00	06600 PHYSICAL THERAPY	5,385,801	0	5,385,801	0	5,385,801	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	11,378,013		11,378,013	0	11,378,013	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,749,411		2,749,411	0	2,749,411	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	33,742,394		33,742,394	0	33,742,394	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	24,848,342		24,848,342	0	24,848,342	73.00
74.00	07400 RENAL DIALYSIS	807,605		807,605	0	807,605	74.00
76.00	03020 OTHER ANCILLARY	0		0	0	0	76.00
76.01	03025 SLEEP LAB	0		0	0	0	76.01
76.03	03026 WOUND CARE	1,777,118		1,777,118	0	1,777,118	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0		0	0	0	90.00
91.00	09100 EMERGENCY	15,940,432		15,940,432	0	15,940,432	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2,417,349		2,417,349	0	2,417,349	92.00
200.00	Subtotal (see instructions)	228,101,476	0	228,101,476	0	228,101,476	200.00
201.00	Less Observation Beds	2,417,349		2,417,349	0	2,417,349	201.00
202.00	Total (see instructions)	225,684,127	0	225,684,127	0	225,684,127	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150035

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/28/2014 3:12 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	93,251,590		93,251,590		30.00
31.00	03100	INTENSIVE CARE UNIT	26,470,319		26,470,319		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	15,148,892		15,148,892		31.01
41.00	04100	SUBPROVIDER - I RF	6,446,993		6,446,993		41.00
43.00	04300	NURSERY	1,453,908		1,453,908		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	127,308,814	139,016,299	266,325,113	0.100905	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,659,350	19,852	11,679,202	0.420415	52.00
53.00	05300	ANESTHESIOLOGY	5,463,830	5,848,184	11,312,014	0.023505	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,108,883	141,598,171	172,707,054	0.101215	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	54.01
56.00	05600	RADIOLOGY	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	57,159,682	87,438,488	144,598,170	0.122195	60.00
65.00	06500	RESPIRATORY THERAPY	12,453,391	1,813,678	14,267,069	0.287148	65.00
66.00	06600	PHYSICAL THERAPY	14,635,886	7,049,377	21,685,263	0.248362	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	33,393,247	54,413,566	87,806,813	0.129580	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,202,132	11,889,212	29,091,344	0.094510	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	90,747,044	48,231,349	138,978,393	0.242789	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	49,990,716	66,567,465	116,558,181	0.213184	73.00
74.00	07400	RENAL DIALYSIS	2,810,185	83,201	2,893,386	0.279121	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0.000000	76.00
76.01	03025	SLEEP LAB	0	0	0	0.000000	76.01
76.03	03026	WOUND CARE	78,592	5,297,047	5,375,639	0.330587	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	30,024,996	83,326,344	113,351,340	0.140629	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	500,000	6,300,380	6,800,380	0.355473	92.00
200.00		Subtotal (see instructions)	627,308,450	658,892,613	1,286,201,063		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	627,308,450	658,892,613	1,286,201,063		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150035	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/28/2014 3:12 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
31.01	03101 NEONATAL INTENSIVE CARE UNIT			31.01
41.00	04100 SUBPROVIDER - I RF			41.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
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
54.01	05401 ULTRASOUND	0.000000		54.01
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
76.00	03020 OTHER ANCILLARY	0.000000		76.00
76.01	03025 SLEEP LAB	0.000000		76.01
76.03	03026 WOUND CARE	0.000000		76.03
<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
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: 150035	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part I Date/Time Prepared: 5/28/2014 3:12 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	5,218,954	0	5,218,954	47,401	110.10	30.00
31.00	INTENSIVE CARE UNIT	930,976		930,976	6,980	133.38	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	334,263		334,263	4,008	83.40	31.01
41.00	SUBPROVIDER - IRF	548,778	0	548,778	3,228	170.01	41.00
43.00	NURSERY	100,853		100,853	1,295	77.88	43.00
200.00	Total (lines 30-199)	7,133,824		7,133,824	62,912		200.00

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

INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	22,580	2,486,058	30.00
31.00	INTENSIVE CARE UNIT	3,793	505,910	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	0	0	31.01
41.00	SUBPROVIDER - IRF	1,969	334,750	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	28,342	3,326,718	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150035

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

Worksheet D  
Part II  
Date/Time Prepared:  
5/28/2014 3:12 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	2,840,763	266,325,113	0.010667	54,821,652	584,783	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	568,208	11,679,202	0.048651	11,292	549	52.00
53.00	05300	ANESTHESIOLOGY	47,255	11,312,014	0.004177	2,104,188	8,789	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,010,446	172,707,054	0.011641	23,921,263	278,467	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	850,249	144,598,170	0.005880	29,759,155	174,984	60.00
65.00	06500	RESPIRATORY THERAPY	170,574	14,267,069	0.011956	7,169,200	85,715	65.00
66.00	06600	PHYSICAL THERAPY	748,795	21,685,263	0.034530	5,995,470	207,024	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,317,478	87,806,813	0.015004	14,969,953	224,609	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	57,971	29,091,344	0.001993	7,930,073	15,805	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	634,416	138,978,393	0.004565	39,596,092	180,756	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	451,739	116,558,181	0.003876	24,353,619	94,395	73.00
74.00	07400	RENAL DIALYSIS	30,356	2,893,386	0.010492	1,762,877	18,496	74.00
76.00	03020	OTHER ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03025	SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03026	WOUND CARE	156,552	5,375,639	0.029122	32,893	958	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	1,521,976	113,351,340	0.013427	15,341,201	205,986	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	331,849	6,800,380	0.048799	382,917	18,686	92.00
200.00		Total (Lines 50-199)	11,738,627	1,143,429,361		228,151,845	2,100,002	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150035		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part III Date/Time Prepared: 5/28/2014 3:12 pm	
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
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	31.01
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	47,401	0.00	22,580	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	6,980	0.00	3,793	0	0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	4,008	0.00	0	0	0	31.01
41.00	04100	SUBPROVIDER - IRF	3,228	0.00	1,969	0	0	41.00
43.00	04300	NURSERY	1,295	0.00	0	0	0	43.00
200.00		Total (lines 30-199)	62,912		28,342	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150035

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/28/2014 3:12 pm

Cost Center Description		Title XVIII				Hospital	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	76.00
76.01	03025	SLEEP LAB	0	0	0	0	76.01
76.03	03026	WOUND CARE	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	74,211	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	74,211	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150035

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/28/2014 3:12 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		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	266,325,113	0.000000	0.000000	54,821,652	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	11,679,202	0.000000	0.000000	11,292	52.00
53.00	05300	ANESTHESIOLOGY	0	11,312,014	0.000000	0.000000	2,104,188	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	172,707,054	0.000000	0.000000	23,921,263	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	144,598,170	0.000000	0.000000	29,759,155	60.00
65.00	06500	RESPIRATORY THERAPY	0	14,267,069	0.000000	0.000000	7,169,200	65.00
66.00	06600	PHYSICAL THERAPY	0	21,685,263	0.000000	0.000000	5,995,470	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	87,806,813	0.000000	0.000000	14,969,953	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	29,091,344	0.000000	0.000000	7,930,073	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	138,978,393	0.000000	0.000000	39,596,092	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	116,558,181	0.000000	0.000000	24,353,619	73.00
74.00	07400	RENAL DIALYSIS	0	2,893,386	0.000000	0.000000	1,762,877	74.00
76.00	03020	OTHER ANCILLARY	0	0	0.000000	0.000000	0	76.00
76.01	03025	SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.03	03026	WOUND CARE	0	5,375,639	0.000000	0.000000	32,893	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	74,211	113,351,340	0.000655	0.000655	15,341,201	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,800,380	0.000000	0.000000	382,917	92.00
200.00		Total (Lines 50-199)	74,211	1,143,429,361			228,151,845	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150035

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/28/2014 3:12 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 VIII Hospital PPS						
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	45,880,671	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,383,216	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	39,094,433	0	54.00
54.01	05401	ULTRASOUND	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
60.00	06000	LABORATORY	0	2,997,453	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	475,179	0	65.00
66.00	06600	PHYSICAL THERAPY	0	14,318	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	21,232,363	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,162,570	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,769,972	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	26,776,777	0	73.00
74.00	07400	RENAL DIALYSIS	0	46,062	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	76.00
76.01	03025	SLEEP LAB	0	0	0	76.01
76.03	03026	WOUND CARE	0	2,683,413	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	10,048	14,912,658	9,768	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,301,795	0	92.00
200.00		Total (Lines 50-199)	10,048	184,730,880	9,768	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150035

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

Worksheet D  
Part V  
Date/Time Prepared:  
5/28/2014 3:12 pm

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	0.100905	45,880,671	0	0	4,629,589	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.420415	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.023505	1,383,216	0	0	32,512	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.101215	39,094,433	0	0	3,956,943	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.122195	2,997,453	14,585	0	366,274	60.00
65.00	06500	RESPIRATORY THERAPY	0.287148	475,179	143	0	136,447	65.00
66.00	06600	PHYSICAL THERAPY	0.248362	14,318	0	0	3,556	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.129580	21,232,363	0	0	2,751,290	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.094510	4,162,570	0	0	393,404	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.242789	22,769,972	0	0	5,528,299	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.213184	26,776,777	0	139,319	5,708,380	73.00
74.00	07400	RENAL DIALYSIS	0.279121	46,062	0	0	12,857	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03025	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03026	WOUND CARE	0.330587	2,683,413	0	0	887,101	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.140629	14,912,658	0	0	2,097,152	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.355473	2,301,795	0	0	818,226	92.00
200.00		Subtotal (see instructions)		184,730,880	14,728	139,319	27,322,030	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		184,730,880	14,728	139,319	27,322,030	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150035	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/28/2014 3:12 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
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 05401 ULTRASOUND	0	0		54.01
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
60.00 06000 LABORATORY	1,782	0		60.00
65.00 06500 RESPIRATORY THERAPY	41	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	29,701		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03020 OTHER ANCILLARY	0	0		76.00
76.01 03025 SLEEP LAB	0	0		76.01
76.03 03026 WOUND CARE	0	0		76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00 Subtotal (see instructions)	1,823	29,701		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	1,823	29,701		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150035	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/28/2014 3:12 pm
		Component CCN: 15T035	Title XVIII	Subprovider - IRF

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,840,763	266,325,113	0.010667	63,935	682	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	568,208	11,679,202	0.048651	0	0	52.00
53.00	05300	ANESTHESIOLOGY	47,255	11,312,014	0.004177	2,650	11	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,010,446	172,707,054	0.011641	216,078	2,515	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	850,249	144,598,170	0.005880	613,389	3,607	60.00
65.00	06500	RESPIRATORY THERAPY	170,574	14,267,069	0.011956	117,788	1,408	65.00
66.00	06600	PHYSICAL THERAPY	748,795	21,685,263	0.034530	2,707,179	93,479	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,317,478	87,806,813	0.015004	37,070	556	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	57,971	29,091,344	0.001993	73,019	146	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	634,416	138,978,393	0.004565	4,869	22	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	451,739	116,558,181	0.003876	694,121	2,690	73.00
74.00	07400	RENAL DIALYSIS	30,356	2,893,386	0.010492	73,206	768	74.00
76.00	03020	OTHER ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03025	SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03026	WOUND CARE	156,552	5,375,639	0.029122	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	1,521,976	113,351,340	0.013427	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,800,380	0.000000	0	0	92.00
200.00		Total (lines 50-199)	11,406,778	1,143,429,361		4,603,304	105,884	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150035  
Component CCN: 15T035

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/28/2014 3:12 pm

Title XVIII

Subprovider -  
IRF

PPS

Cost Center Description			Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
			1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03025	SLEEP LAB	0	0	0	0	0	76.01
76.03	03026	WOUND CARE	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	74,211	0	74,211	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	74,211	0	74,211	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150035

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/28/2014 3:12 pm

Component CCN: 15T035

Title XVIII

Subprovider -  
IRF

PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	266,325,113	0.000000	0.000000	63,935	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	11,679,202	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	11,312,014	0.000000	0.000000	2,650	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	172,707,054	0.000000	0.000000	216,078	54.00
54.01	05401 ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000 LABORATORY	0	144,598,170	0.000000	0.000000	613,389	60.00
65.00	06500 RESPIRATORY THERAPY	0	14,267,069	0.000000	0.000000	117,788	65.00
66.00	06600 PHYSICAL THERAPY	0	21,685,263	0.000000	0.000000	2,707,179	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	87,806,813	0.000000	0.000000	37,070	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	29,091,344	0.000000	0.000000	73,019	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	138,978,393	0.000000	0.000000	4,869	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	116,558,181	0.000000	0.000000	694,121	73.00
74.00	07400 RENAL DIALYSIS	0	2,893,386	0.000000	0.000000	73,206	74.00
76.00	03020 OTHER ANCILLARY	0	0	0.000000	0.000000	0	76.00
76.01	03025 SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.03	03026 WOUND CARE	0	5,375,639	0.000000	0.000000	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	74,211	113,351,340	0.000655	0.000655	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	6,800,380	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	74,211	1,143,429,361			4,603,304	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150035	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/28/2014 3:12 pm
	Component CCN: 15T035	Title XVIII	Subprovider - IRF PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01 05401 ULTRASOUND	0	0	0	54.01
56.00 05600 RADIOISOTOPE	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	57.00
58.00 05800 MRI	0	0	0	58.00
60.00 06000 LABORATORY	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	74.00
76.00 03020 OTHER ANCILLARY	0	0	0	76.00
76.01 03025 SLEEP LAB	0	0	0	76.01
76.03 03026 WOUND CARE	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150035	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/28/2014 3:12 pm
		Title XIX	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.100905	0	0	2,540,966	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.420415	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.023505	0	0	98,478	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.101215	0	0	4,837,026	0	54.00
54.01	05401 ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MRI	0.000000	0	0	0	0	58.00
60.00	06000 LABORATORY	0.122195	0	0	2,781,913	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.287148	0	0	77,544	0	65.00
66.00	06600 PHYSICAL THERAPY	0.248362	0	0	188,110	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.129580	0	0	1,520,755	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.094510	0	0	187,023	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.242789	0	0	1,115,609	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.213184	0	0	4,223,535	0	73.00
74.00	07400 RENAL DIALYSIS	0.279121	0	0	0	0	74.00
76.00	03020 OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03025 SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03026 WOUND CARE	0.330587	0	0	182,134	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.140629	0	0	4,521,292	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.355473	0	0	306,026	0	92.00
200.00	Subtotal (see instructions)		0	0	22,580,411	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	22,580,411	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150035

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

Worksheet D  
Part V  
Date/Time Prepared:  
5/28/2014 3:12 pm

		Title XIX		Hospital	Cost
Cost Center Description	Costs		Cost	Cost	
	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	256,396	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,315	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	489,580	54.00
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	339,936	60.00
65.00	06500	RESPIRATORY THERAPY	0	22,267	65.00
66.00	06600	PHYSICAL THERAPY	0	46,719	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	197,059	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	17,676	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	270,858	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	900,390	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	76.00
76.01	03025	SLEEP LAB	0	0	76.01
76.03	03026	WOUND CARE	0	60,211	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	635,825	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	108,784	92.00
200.00		Subtotal (see instructions)	0	3,348,016	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	3,348,016	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150035	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/28/2014 3:12 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)		47,401	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		47,401	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)		44,387	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)		22,580	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)		38,017,421	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)		38,017,421	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)		38,017,421	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)		802.04	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		18,110,063	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)		18,110,063	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150035		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 5/28/2014 3:12 pm	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	12,481,877	6,980	1,788.23	3,793	6,782,756		43.00
43.01 NEONATAL INTENSIVE CARE UNIT	3,587,246	4,008	895.02	0	0		43.01
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)					35,482,305		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					60,375,124		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)					2,991,968		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,110,050		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					5,102,018		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					55,273,106		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)					3,014		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					802.04		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					2,417,349		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150035		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/28/2014 3:12 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	5,218,954	38,017,421	0.137278	2,417,349	331,849	90.00
91.00	Nursing School cost	0	38,017,421	0.000000	2,417,349	0	91.00
92.00	Allied health cost	0	38,017,421	0.000000	2,417,349	0	92.00
93.00	All other Medical Education	0	38,017,421	0.000000	2,417,349	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150035	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Component CCN: 15T035		Date/Time Prepared: 5/28/2014 3:12 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,228	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,228	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)		3,228	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,969	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)		2,997,404	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,997,404	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)		2,997,404	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)		928.56	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,828,335	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,828,335	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150035		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
		Component CCN: 15T035				Date/Time Prepared: 5/28/2014 3:12 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00	
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00	
43.01 NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	43.01	
44.00 CORONARY CARE UNIT						44.00	
45.00 BURN INTENSIVE CARE UNIT						45.00	
46.00 SURGICAL INTENSIVE CARE UNIT						46.00	
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00	
<b>Cost Center Description</b>							
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					990,814	48.00	
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,819,149	49.00	
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					334,750	50.00	
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					105,884	51.00	
52.00 Total Program excludable cost (sum of lines 50 and 51)					440,634	52.00	
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,378,515	53.00	
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
54.00 Program discharges					0	54.00	
55.00 Target amount per discharge					0.00	55.00	
56.00 Target amount (line 54 x line 55)					0	56.00	
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00	
58.00 Bonus payment (see instructions)					0	58.00	
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00	
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00	
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00	
62.00 Relief payment (see instructions)					0	62.00	
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00	
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00	
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00	
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00	
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00	
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00	
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00	
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00	
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00	
72.00 Program routine service cost (line 9 x line 71)						72.00	
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00	
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00	
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00	
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00	
77.00 Program capital-related costs (line 9 x line 76)						77.00	
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00	
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00	
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00	
81.00 Inpatient routine service cost per diem limitation						81.00	
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00	
83.00 Reasonable inpatient routine service costs (see instructions)						83.00	
84.00 Program inpatient ancillary services (see instructions)						84.00	
85.00 Utilization review - physician compensation (see instructions)						85.00	
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00	
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00	
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150035 Component CCN: 15T035		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/28/2014 3:12 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	548,778	2,997,404	0.183084	0	0	90.00
91.00	Nursing School cost	0	2,997,404	0.000000	0	0	91.00
92.00	Allied health cost	0	2,997,404	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,997,404	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150035	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/28/2014 3:12 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		48,042,804	30.00
31.00	03100	INTENSIVE CARE UNIT		14,386,476	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		0	31.01
41.00	04100	SUBPROVIDER - I RF		0	41.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.100905	54,821,652	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.420415	11,292	52.00
53.00	05300	ANESTHESIOLOGY	0.023505	2,104,188	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.101215	23,921,263	54.00
54.01	05401	ULTRASOUND	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MRI	0.000000	0	58.00
60.00	06000	LABORATORY	0.122195	29,759,155	60.00
65.00	06500	RESPIRATORY THERAPY	0.287148	7,169,200	65.00
66.00	06600	PHYSICAL THERAPY	0.248362	5,995,470	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.129580	14,969,953	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.094510	7,930,073	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.242789	39,596,092	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.213184	24,353,619	73.00
74.00	07400	RENAL DIALYSIS	0.279121	1,762,877	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	76.00
76.01	03025	SLEEP LAB	0.000000	0	76.01
76.03	03026	WOUND CARE	0.330587	32,893	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	0.140629	15,341,201	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.355473	382,917	92.00
200.00		Total (sum of lines 50-94 and 96-98)		228,151,845	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)		228,151,845	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150035 Component CCN: 15T035	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/28/2014 3:12 pm
		Title XVIIII	Subprovider - IRF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
31.01	03101 NEONATAL INTENSIVE CARE UNIT		0	31.01
41.00	04100 SUBPROVIDER - IRF		3,927,565	41.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.100905	63,935	6,451 50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.420415	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.023505	2,650	62 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.101215	216,078	21,870 54.00
54.01	05401 ULTRASOUND	0.000000	0	0 54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0 56.00
57.00	05700 CT SCAN	0.000000	0	0 57.00
58.00	05800 MRI	0.000000	0	0 58.00
60.00	06000 LABORATORY	0.122195	613,389	74,953 60.00
65.00	06500 RESPIRATORY THERAPY	0.287148	117,788	33,823 65.00
66.00	06600 PHYSICAL THERAPY	0.248362	2,707,179	672,360 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.129580	37,070	4,804 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.094510	73,019	6,901 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.242789	4,869	1,182 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.213184	694,121	147,975 73.00
74.00	07400 RENAL DIALYSIS	0.279121	73,206	20,433 74.00
76.00	03020 OTHER ANCILLARY	0.000000	0	0 76.00
76.01	03025 SLEEP LAB	0.000000	0	0 76.01
76.03	03026 WOUND CARE	0.330587	0	0 76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000	0	0 90.00
91.00	09100 EMERGENCY	0.140629	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.355473	0	0 92.00
200.00	Total (sum of lines 50-94 and 96-98)		4,603,304	990,814 200.00
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)		4,603,304	990,814 202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150035	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/28/2014 3:12 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		4,577,844	30.00
31.00	03100	INTENSIVE CARE UNIT		1,691,810	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		1,520,404	31.01
41.00	04100	SUBPROVIDER - I RF		0	41.00
43.00	04300	NURSERY		90,635	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.100905	3,429,334	346,037 50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.420415	411,449	172,979 52.00
53.00	05300	ANESTHESIOLOGY	0.023505	150,946	3,548 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.101215	1,628,543	164,833 54.00
54.01	05401	ULTRASOUND	0.000000	0	0 54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0 56.00
57.00	05700	CT SCAN	0.000000	0	0 57.00
58.00	05800	MRI	0.000000	0	0 58.00
60.00	06000	LABORATORY	0.122195	3,131,186	382,615 60.00
65.00	06500	RESPIRATORY THERAPY	0.287148	1,006,026	288,878 65.00
66.00	06600	PHYSICAL THERAPY	0.248362	627,730	155,904 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.129580	1,426,261	184,815 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.094510	443,366	41,903 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.242789	1,498,421	363,800 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.213184	1,153,201	245,844 73.00
74.00	07400	RENAL DIALYSIS	0.279121	12,600	3,517 74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0 76.00
76.01	03025	SLEEP LAB	0.000000	0	0 76.01
76.03	03026	WOUND CARE	0.330587	2,734	904 76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.000000	0	0 90.00
91.00	09100	EMERGENCY	0.140629	1,420,021	199,696 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.355473	0	0 92.00
200.00		Total (sum of lines 50-94 and 96-98)		16,341,818	2,555,273 200.00
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)		16,341,818	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150035 Component CCN: 15T035	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/28/2014 3:12 pm
		Title XIX	Subprovider - IRF	Cost
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
31.01	03101 NEONATAL INTENSIVE CARE UNIT		0	31.01
41.00	04100 SUBPROVIDER - IRF		460,436	41.00
43.00	04300 NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.100905	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.420415	0	52.00
53.00	05300 ANESTHESIOLOGY	0.023505	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.101215	0	54.00
54.01	05401 ULTRASOUND	0.000000	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	56.00
57.00	05700 CT SCAN	0.000000	0	57.00
58.00	05800 MRI	0.000000	0	58.00
60.00	06000 LABORATORY	0.122195	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.287148	0	65.00
66.00	06600 PHYSICAL THERAPY	0.248362	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.129580	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.094510	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.242789	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.213184	0	73.00
74.00	07400 RENAL DIALYSIS	0.279121	0	74.00
76.00	03020 OTHER ANCILLARY	0.000000	0	76.00
76.01	03025 SLEEP LAB	0.000000	0	76.01
76.03	03026 WOUND CARE	0.330587	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000	0	90.00
91.00	09100 EMERGENCY	0.140629	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.355473	0	92.00
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: 150035	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/28/2014 3:12 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)		33,010,317	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		10,884,647	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)		2,743,796	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)		229.74	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)		3.04	30.00
31.00	Percentage of Medicaid patient days (see instructions)		15.61	31.00
32.00	Sum of lines 30 and 31		18.65	32.00
33.00	Allowable disproportionate share percentage (see instructions)		4.87	33.00
34.00	Disproportionate share adjustment (see instructions)		1,740,123	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150035	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/28/2014 3:12 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)			0.028224200	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			2,553,267	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			643,564	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		643,564		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)		49,022,447		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)			0	48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		49,022,447		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		3,731,372		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			778	53.00
54.00	Special add-on payments for new technologies			8,172	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)			10,048	58.00
59.00	Total (sum of amounts on lines 49 through 58)		52,772,817		59.00
60.00	Primary payer payments			36,565	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		52,736,252		61.00
62.00	Deductibles billed to program beneficiaries			4,405,988	62.00
63.00	Coinurance billed to program beneficiaries			364,527	63.00
64.00	Allowable bad debts (see instructions)			231,020	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			150,163	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			231,020	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		48,115,900		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)			83,280	70.93
70.94	Hospital readmissions reduction adjustment (see instructions)			-9,905	70.94
70.95	Recovery of Accelerated Depreciation			0	70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150035	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/28/2014 3:12 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)		48,189,275		71.00
71.01	Sequestration adjustment (see instructions)		727,658		71.01
72.00	Interim payments		47,697,379		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		-235,762		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		2,698,940		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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150035	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/28/2014 3:12 pm
		Title XVII	Hospital	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		31,524	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		27,312,262	2.00
3.00	PPS payments		25,118,373	3.00
4.00	Outlier payment (see instructions)		173,711	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		9,768	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		31,524	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		154,047	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)		154,047	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)		154,047	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		122,523	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)		31,524	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)		25,301,852	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		29	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		5,347,167	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)		19,986,180	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)		19,986,180	30.00
31.00	Primary payer payments		19,157	31.00
32.00	Subtotal (line 30 minus line 31)		19,967,023	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)		368,546	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		239,555	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		368,546	36.00
37.00	Subtotal (see instructions)		20,206,578	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		20,206,578	40.00
40.01	Sequestration adjustment (see instructions)		305,119	40.01
41.00	Interim payments		19,905,298	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-3,839	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: 150035

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/28/2014 3:12 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		47,697,379		19,905,298	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)		47,697,379		19,905,298	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		235,762		3,839	6.02	
7.00	Total Medicare program liability (see instructions)		47,461,617		19,901,459	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: 150035  
Component CCN: 15T035

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/28/2014 3:12 pm

Title XVIII

Subprovider -  
IRF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					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		2,670,781		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)		2,670,781		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		55,822		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,726,603		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: 150035	Period: From 01/01/2013 To 12/31/2013	Worksheet E-1 Part II Date/Time Prepared: 5/28/2014 3:12 pm
		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			12,976 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			26,373 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			4,623 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			55,375 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			1,286,201,063 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			4,618,414 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)			2,452,482 8.00
9.00	Sequestration adjustment amount (see instructions)			49,050 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			2,403,432 10.00
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			2,278,666 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)			124,766 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150035 Component CCN: 15T035	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part III Date/Time Prepared: 5/28/2014 3:12 pm
		Title XVIIII	Subprovider - IRF	PPS
		Prior to 10/01	On/After 10/01	
		1.00	1.01	
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)	1,854,935	644,104	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0303		2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	94,602	22,479	3.00
4.00	Outlier Payments	169,871		4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00		5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00		5.01
6.00	New Teaching program adjustment. (see instructions)	0.00		6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program". (see inst.)	0.00		7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program". (see inst.)	0.00		8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00		9.00
10.00	Average Daily Census (see instructions)	8.843836		10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	0	12.00
13.00	Total PPS Payment (see instructions)	2,785,991		13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0		14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			15.00
16.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0		16.00
17.00	Subtotal (see instructions)	2,785,991		17.00
18.00	Primary payer payments	2,489		18.00
19.00	Subtotal (line 17 less line 18).	2,783,502		19.00
20.00	Deductibles	5,920		20.00
21.00	Subtotal (line 19 minus line 20)	2,777,582		21.00
22.00	Coinurance	9,176		22.00
23.00	Subtotal (line 21 minus line 22)	2,768,406		23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0		24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0		25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		26.00
27.00	Subtotal (sum of lines 23 and 25)	2,768,406		27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0		28.00
29.00	Other pass through costs (see instructions)	0		29.00
30.00	Outlier payments reconciliation	0		30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		31.00
31.99	Recovery of Accelerated Depreciation	0		31.99
32.00	Total amount payable to the provider (see instructions)	2,768,406		32.00
32.01	Sequestration adjustment (see instructions)	41,803		32.01
33.00	Interim payments	2,670,781		33.00
34.00	Tentative settlement (for contractor use only)	0		34.00
35.00	Balance due provider/program line 32 minus lines 32.01, 33 and 34	55,822		35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	11,496		36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4	169,871		50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0		51.00
52.00	The rate used to calculate the Time Value of Money	0.00		52.00
53.00	Time Value of Money (see instructions)	0		53.00

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

Provider CCN: 150035

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

Worksheet G

Date/Time Prepared:  
5/28/2014 3:12 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	-277,257	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	54,351,136	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-15,623,299	0	0	0	6.00
7.00	Inventory	7,597,836	0	0	0	7.00
8.00	Prepaid expenses	1,557,977	0	0	0	8.00
9.00	Other current assets	550,072	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)	48,156,465	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	15,980,775	0	0	0	12.00
13.00	Land improvements	5,092,532	0	0	0	13.00
14.00	Accumulated depreciation	-1,727,032	0	0	0	14.00
15.00	Buildings	199,186,019	0	0	0	15.00
16.00	Accumulated depreciation	-21,762,821	0	0	0	16.00
17.00	Leasehold improvements	6,177,838	0	0	0	17.00
18.00	Accumulated depreciation	-3,713,605	0	0	0	18.00
19.00	Fixed equipment	6,261,769	0	0	0	19.00
20.00	Accumulated depreciation	-1,230,123	0	0	0	20.00
21.00	Automobiles and trucks	302,979	0	0	0	21.00
22.00	Accumulated depreciation	-216,370	0	0	0	22.00
23.00	Major movable equipment	52,722,287	0	0	0	23.00
24.00	Accumulated depreciation	-20,663,025	0	0	0	24.00
25.00	Minor equipment depreciable	15,867,321	0	0	0	25.00
26.00	Accumulated depreciation	-8,315,566	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)	243,962,978	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	9,017,237	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	9,017,237	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	301,136,680	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	11,699,705	0	0	0	37.00
38.00	Salaries, wages, and fees payable	9,595,624	0	0	0	38.00
39.00	Payroll taxes payable	1,079,770	0	0	0	39.00
40.00	Notes and loans payable (short term)	694	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	45,377,083	0	0	0	43.00
44.00	Other current liabilities	2,972,405	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	70,725,281	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	15,552,703	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	15,552,703	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	86,277,984	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	214,858,696	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	214,858,696	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	301,136,680	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150035

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

Worksheet G-1

Date/Time Prepared:  
5/28/2014 3:12 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		178,938,514		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		35,920,182			2.00
3.00	Total (sum of line 1 and line 2)		214,858,696		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)		214,858,696		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)		214,858,696		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: 150035

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/28/2014 3:12 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	94,705,498		94,705,498	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	6,446,993		6,446,993	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	101,152,491		101,152,491	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	26,470,319		26,470,319	11.00
11.01	NEONATAL INTENSIVE CARE UNIT	15,148,892		15,148,892	11.01
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)	41,619,211		41,619,211	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	142,771,702		142,771,702	17.00
18.00	Ancillary services	454,011,752	569,265,889	1,023,277,641	18.00
19.00	Outpatient services	30,524,996	89,626,724	120,151,720	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	627,308,450	658,892,613	1,286,201,063	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		284,471,734		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)		284,471,734		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150035

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

Worksheet G-3

Date/Time Prepared:  
5/28/2014 3:12 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,286,201,063	1.00
2.00	Less contractual allowances and discounts on patients' accounts	971,186,883	2.00
3.00	Net patient revenues (line 1 minus line 2)	315,014,180	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	284,471,734	4.00
5.00	Net income from service to patients (line 3 minus line 4)	30,542,446	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	MISC INCOME	5,377,736	24.00
24.01		0	24.01
25.00	Total other income (sum of lines 6-24)	5,377,736	25.00
26.00	Total (line 5 plus line 25)	35,920,182	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)	35,920,182	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150035	Period: From 01/01/2013 To 12/31/2013	Worksheet L Parts I-III Date/Time Prepared: 5/28/2014 3:12 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		3,477,900	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		119,573	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)		151.71	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)		3.04	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		15.61	8.00
9.00	Sum of lines 7 and 8		18.65	9.00
10.00	Allowable disproportionate share percentage (see instructions)		3.85	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		133,899	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		3,731,372	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