

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: 151311	Period: From 01/01/2013 To 12/31/2013	Worksheet S Parts I-III Date/Time Prepared: 6/2/2014 9:14 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 6/2/2014 Time: 9:14 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH TIPTON HOSPITAL (151311) 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)

_____ CHIEF FINANCIAL OFFICER
Title

_____ Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	469,369	-718,275	68,583	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	184,960	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	654,329	-718,275	68,583	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: 151311	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/24/2014 10:35 am
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1.00	2.00	3.00	4.00	1.00	2.00
Hospital and Hospital Health Care Complex Address:					
Street: 1000 SOUTH MAIN STREET		PO Box:			
City: TIPTON		State: IN		Zip Code: 46072	
				County: TIPTON	

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
						V	XVIII	XIX	
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	IU HEALTH TIPTON HOSPITAL	151311	29020	1	11/12/2005	N	0	0	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	IU HEALTH TIPTON HOSPITAL	15Z311	29020		11/12/2005	N	0	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - 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)					2		21.00	

Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					N	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	Medicaid HMO days	Other Medicaid days	
24.00	0	0	0	0	0	0	24.00
25.00	0	0	0	0	0	0	25.00

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		Urban/Rural S	Date of Geogr			
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0			35.00	
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N		39.00	
		V	XVII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		
61.04	Enter the number of unweighted primary care/surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		

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

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

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		V	XIX			
		1.00	2.00			
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column. Rural Providers	0.00	0.00		97.00	
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y			105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00	
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00	
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	67,014	0	0		118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02	
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00	
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00

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		1.00	2.00			
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H059	140.00		
		1.00	2.00	3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141.00	Name: INDIANA UNIVERSITY HEALTH	Contractor's Name: WPS		Contractor's Number: 08101		
142.00	Street: 310 WEST 10TH STREET	PO Box:				
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46204		
				1.00		
144.00	Are provider based physicians' costs included in Worksheet A?	Y		144.00		
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N		145.00		
				1.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00		
		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	N	
156.00	Subprovider - IPF	N	N	N	N	
157.00	Subprovider - IRF	N	N	N	N	
158.00	SUBPROVIDER					
159.00	SNF	N	N	N	N	
160.00	HOME HEALTH AGENCY	N	N	N	N	
161.00	CMHC		N	N	N	
				1.00		
Multi campus						
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N		165.00		
		Name	County	State	Zip Code	CBSA
		0	1.00	2.00	3.00	4.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5					0.00
				1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act						
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y		167.00		
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	78,123		168.00		
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00		169.00		
		Begining		Ending		
		1.00		2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2012		09/30/2013		

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151311	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/24/2014 10:35 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C	04/30/2014	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		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	05/13/2014	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151311	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/24/2014 10:35 am	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			Y	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA		UTTER	41.00
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.962.1093		RUTTER@IUHEALTH.ORG	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	05/13/2014	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER, GOV' T PROGRAMS	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: 151311

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

Worksheet S-3
Part I
Date/Time Prepared:
5/24/2014 10:35 am

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	19	6,935	64,176.00	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)		19	6,935	64,176.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	6	2,190	14,880.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	79,056.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		25				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: 151311

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

Worksheet S-3
Part I
Date/Time Prepared:
5/24/2014 10:35 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,649	38	2,674			1.00
2.00 HMO and other (see instructions)	231	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	1,590	0	1,590			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		27	274			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	3,239	65	4,538			7.00
8.00 INTENSIVE CARE UNIT	412	9	620			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	3,651	74	5,158	0.00	280.41	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	280.41	27.00
28.00 Observation Bed Days		0	0			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: 151311

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

Worksheet S-3
Part I
Date/Time Prepared:
5/24/2014 10:35 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	580	24	955	1.00
2.00 HMO and other (see instructions)				66			2.00
3.00 HMO IPF Subprovider							3.00
4.00 HMO IRF Subprovider							4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0	580	24	955		14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 151311	Period: From 01/01/2013 To 12/31/2013	Worksheet S-10 Date/Time Prepared: 5/24/2014 10:35 am
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			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.410940	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		3,786,000	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		2,058,000	6.00
7.00	Medicaid cost (line 1 times line 6)		845,715	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone SCHIP		0	9.00
10.00	Stand-alone SCHIP charges		0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Uncompensated care (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00
			1.00	
			2.00	
			3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	0	0	0
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	0	0	0
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	0	0	0
			1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		3,012,000	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		542,717	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		2,469,283	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,014,727	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,014,727	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,014,727	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 151311	Period: From 01/01/2013 To 12/31/2013	Worksheet A Date/Time Prepared: 5/24/2014 10:35 am	
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		1,817,403	1,817,403	-1,342,200	475,203	1.00
1.01	00101		947,015	947,015	0	947,015	1.01
2.00	00200		0	0	1,342,200	1,342,200	2.00
4.00	00400	12,001	4,387,238	4,399,239	31,157	4,430,396	4.00
5.01	00510	345,333	98,938	444,271	21,253	465,524	5.01
5.02	00520	268,992	399,236	668,228	-2,464	665,764	5.02
5.06	00560	1,424,981	3,011,219	4,436,200	-227,298	4,208,902	5.06
7.00	00700	24,859	2,341,915	2,366,774	-129,231	2,237,543	7.00
7.01	00701	0	0	0	0	0	7.01
8.00	00800	0	82,597	82,597	-2,688	79,909	8.00
9.00	00900	314,105	77,730	391,835	-70,819	321,016	9.00
10.00	01000	387,647	243,807	631,454	-241,394	390,060	10.00
11.00	01100	0	0	0	238,933	238,933	11.00
13.00	01300	257,630	10,700	268,330	144,896	413,226	13.00
14.00	01400	114,563	2,312,932	2,427,495	-1,851,072	576,423	14.00
15.00	01500	511,750	2,079,989	2,591,739	-1,914,942	676,797	15.00
16.00	01600	228,749	172,287	401,036	-3,783	397,253	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,638,289	46,703	1,684,992	-26,665	1,658,327	30.00
31.00	03100	633,391	7,276	640,667	-6,602	634,065	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,215,820	173,505	1,389,325	-124,221	1,265,104	50.00
53.00	05300	178,050	507,959	686,009	-13,062	672,947	53.00
54.00	05400	885,041	420,413	1,305,454	-75,162	1,230,292	54.00
60.00	06000	945,849	817,320	1,763,169	-401,041	1,362,128	60.00
64.00	06400	0	26,335	26,335	-26,335	0	64.00
65.00	06500	360,686	9,906	370,592	22,058	392,650	65.00
66.00	06600	729,204	113,032	842,236	-105,305	736,931	66.00
67.00	06700	245,366	22,278	267,644	48,606	316,250	67.00
69.00	06900	258,241	156,262	414,503	-21,150	393,353	69.00
71.00	07100	0	0	0	1,861,347	1,861,347	71.00
72.00	07200	0	0	0	1,269,469	1,269,469	72.00
73.00	07300	0	0	0	1,898,545	1,898,545	73.00
73.02	07302	229,257	21,495	250,752	-8,253	242,499	73.02
76.97	07697	52,938	1,112	54,050	-1,017	53,033	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	2,019,445	113,289	2,132,734	-15,411	2,117,323	91.00
92.00	09200						92.00
92.01	09201	481,066	1,595	482,661	-1,074	481,587	92.01
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		13,763,253	20,421,486	34,184,739	267,275	34,452,014	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	16,342	78,580	94,922	-4,646	90,276	190.01
190.02	19002	1,064	16,973	18,037	-16,973	1,064	190.02
191.00	19100	0	0	0	0	0	191.00
191.04	19104	0	0	0	0	0	191.04
191.06	19106	0	36,123	36,123	-352	35,771	191.06
192.00	19200	4,312,407	1,090,032	5,402,439	-190,692	5,211,747	192.00
192.01	19201	43,885	40,159	84,044	-16,114	67,930	192.01
192.02	19202	184,104	171,992	356,096	-4,178	351,918	192.02
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
194.00	07950	59,156	40,862	100,018	-34,320	65,698	194.00
194.01	07951	0	0	0	0	0	194.01
194.04	07954	0	36,602	36,602	0	36,602	194.04
200.00		18,380,211	21,932,809	40,313,020	0	40,313,020	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151311

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

Worksheet A
Date/Time Prepared:
5/24/2014 10:35 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	964,868	1,440,071	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTEREST	-394,122	552,893	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	278,421	1,620,621	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	288,134	4,718,530	4.00
5.01	00510	COMMUNICATIONS	-5,039	460,485	5.01
5.02	00520	PATIENT ACCOUNTING	54,322	720,086	5.02
5.06	00560	OTHER ADMINISTRATIVE & GENERAL	1,144,657	5,353,559	5.06
7.00	00700	OPERATION OF PLANT	238,793	2,476,336	7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	79,909	8.00
9.00	00900	HOUSEKEEPING	35,659	356,675	9.00
10.00	01000	DIETARY	-25,841	364,219	10.00
11.00	01100	CAFETERIA	-73,342	165,591	11.00
13.00	01300	NURSING ADMINISTRATION	-244	412,982	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	733	577,156	14.00
15.00	01500	PHARMACY	-408,964	267,833	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-9,242	388,011	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,658,327	30.00
31.00	03100	INTENSIVE CARE UNIT	0	634,065	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,265,104	50.00
53.00	05300	ANESTHESIOLOGY	-178,050	494,897	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,230,292	54.00
60.00	06000	LABORATORY	-139,772	1,222,356	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	392,650	65.00
66.00	06600	PHYSICAL THERAPY	-1,426	735,505	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	316,250	67.00
69.00	06900	ELECTROCARDIOLOGY	0	393,353	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,861,347	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,269,469	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,898,545	73.00
73.02	07302	ONCOLOGY	0	242,499	73.02
76.97	07697	CARDIAC REHABILITATION	0	53,033	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-686,387	1,430,936	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	481,587	92.01
OTHER REIMBURSABLE COST CENTERS					
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,083,158	35,535,172	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	0	90,276	190.01
190.02	19002	HEALTH MINISTRY	0	1,064	190.02
191.00	19100	RESEARCH	0	0	191.00
191.04	19104	MEALS ON WHEELS	0	0	191.04
191.06	19106	ASSISTED LIVING	0	35,771	191.06
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,211,747	192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	67,930	192.01
192.02	19202	MEDICAL NETWORK	0	351,918	192.02
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	IUH HOME HEALTH AGENCY	0	0	193.01
194.00	07950	COMMUNITY FITNESS	0	65,698	194.00
194.01	07951	VACANT SPACE	0	0	194.01
194.04	07954	FOUNDATION	0	36,602	194.04
200.00		TOTAL (SUM OF LINES 118-199)	1,083,158	41,396,178	200.00

RECLASSIFICATIONS

Provider CCN: 151311

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

Worksheet A-6

Date/Time Prepared:
5/24/2014 10:35 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	146,680	92,253	1.00
	TOTALS		146,680	92,253	
B - VP OF NURSING COSTS					
1.00	NURSING ADMINISTRATION	13.00	148,888	0	1.00
	TOTALS		148,888	0	
C - FITNESS CENTER					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	18,428	12,729	1.00
	TOTALS		18,428	12,729	
D - SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	461,022	1.00
2.00	RESPIRATORY THERAPY	65.00	0	32,039	2.00
3.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,861,347	3.00
4.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,269,469	4.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,898,545	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
	TOTALS		0	5,522,422	
E - EQUIPMENT DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,342,200	1.00
	TOTALS		0	1,342,200	
F - ORTHOPEDIC					
1.00	OCCUPATIONAL THERAPY	67.00	51,123	0	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	25,561	0	2.00
	TOTALS		76,684	0	
G - OVERHEAD COSTS IN NRCC					
1.00	COMMUNICATIONS	5.01	0	30,954	1.00
2.00	OPERATION OF PLANT	7.00	0	49,949	2.00
	TOTALS		0	80,903	
500.00	Grand Total: Increases		390,680	7,050,507	500.00

RECLASSIFICATIONS

Provider CCN: 151311

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

Worksheet A-6

Date/Time Prepared:
5/24/2014 10:35 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA							
1.00	DIETARY	10.00	146,680	92,253	0		1.00
	TOTALS		146,680	92,253			
B - VP OF NURSING COSTS							
1.00	OTHER ADMINISTRATIVE & GENERAL	5.06	148,888	0	0		1.00
	TOTALS		148,888	0			
C - FITNESS CENTER							
1.00	COMMUNITY FITNESS	194.00	18,428	12,729	0		1.00
	TOTALS		18,428	12,729			
D - SUPPLIES							
1.00	COMMUNICATIONS	5.01	0	9,701	0		1.00
2.00	PATIENT ACCOUNTING	5.02	0	2,464	0		2.00
3.00	OTHER ADMINISTRATIVE & GENERAL	5.06	0	78,410	0		3.00
4.00	OPERATION OF PLANT	7.00	0	179,180	0		4.00
5.00	LAUNDRY & LINEN SERVICE	8.00	0	2,688	0		5.00
6.00	HOUSEKEEPING	9.00	0	70,819	0		6.00
7.00	DIETARY	10.00	0	2,461	0		7.00
8.00	NURSING ADMINISTRATION	13.00	0	3,992	0		8.00
9.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,312,094	0		9.00
10.00	PHARMACY	15.00	0	1,914,942	0		10.00
11.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,783	0		11.00
12.00	ADULTS & PEDIATRICS	30.00	0	26,665	0		12.00
13.00	INTENSIVE CARE UNIT	31.00	0	6,602	0		13.00
14.00	OPERATING ROOM	50.00	0	124,221	0		14.00
15.00	ANESTHESIOLOGY	53.00	0	13,062	0		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	75,162	0		16.00
17.00	LABORATORY	60.00	0	401,041	0		17.00
18.00	INTRAVENOUS THERAPY	64.00	0	26,335	0		18.00
19.00	RESPIRATORY THERAPY	65.00	0	9,981	0		19.00
20.00	PHYSICAL THERAPY	66.00	0	28,621	0		20.00
21.00	OCCUPATIONAL THERAPY	67.00	0	2,517	0		21.00
22.00	ELECTROCARDIOLOGY	69.00	0	21,150	0		22.00
23.00	ONCOLOGY	73.02	0	8,253	0		23.00
24.00	CARDIAC REHABILITATION	76.97	0	1,017	0		24.00
25.00	EMERGENCY	91.00	0	15,411	0		25.00
26.00	OBSERVATION BEDS (DISTINCT PART)	92.01	0	1,074	0		26.00
27.00	MARKETING/PUBLIC RELATIONS	190.01	0	4,646	0		27.00
28.00	HEALTH MINISTRY	190.02	0	16,973	0		28.00
29.00	ASSISTED LIVING	191.06	0	352	0		29.00
30.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	135,350	0		30.00
31.00	OCCUPATIONAL MEDICINE	192.01	0	16,114	0		31.00
32.00	MEDICAL NETWORK	192.02	0	4,178	0		32.00
33.00	COMMUNITY FITNESS	194.00	0	3,163	0		33.00
	TOTALS		0	5,522,422			
E - EQUIPMENT DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,342,200	9		1.00
	TOTALS		0	1,342,200			
F - ORTHOPEDIC							
1.00	PHYSICAL THERAPY	66.00	76,684	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		76,684	0			
G - OVERHEAD COSTS IN NRCC							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	80,903	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	80,903			
500.00	Grand Total: Decreases		390,680	7,050,507			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151311

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

Worksheet A-7
Part I
Date/Time Prepared:
5/24/2014 10:35 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	1,294,500	0	0	2,788	4.00
5.00	Fixed Equipment	1,318,614	168,360	0	0	5.00
6.00	Movable Equipment	5,945,353	785,106	0	785,106	6.00
7.00	HIT designated Assets	1,264,439	78,123	0	78,123	7.00
8.00	Subtotal (sum of lines 1-7)	9,822,906	1,031,589	0	1,031,589	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	9,822,906	1,031,589	0	538,569	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	1,291,712	127,539			4.00
5.00	Fixed Equipment	1,486,974	404,947			5.00
6.00	Movable Equipment	6,730,459	1,396,240			6.00
7.00	HIT designated Assets	806,781	0			7.00
8.00	Subtotal (sum of lines 1-7)	10,315,926	1,928,726			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	10,315,926	1,928,726			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151311

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

Worksheet A-7
Part II
Date/Time Prepared:
5/24/2014 10:35 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	1,389,403	394,665	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTEREST	0	0	947,015	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,389,403	394,665	947,015	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	33,335	1,817,403	1.00			
1.01	CAP REL COSTS-BLDG & FIXT - INTEREST	0	947,015	1.01			
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00			
3.00	Total (sum of lines 1-2)	33,335	2,764,418	3.00			

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151311

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

Worksheet A-7
Part III
Date/Time Prepared:
5/24/2014 10:35 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	2,778,686	0	2,778,686	0.292212	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTEREST	0	0	0	0.000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	6,730,459	0	6,730,459	0.707788	0	2.00
3.00	Total (sum of lines 1-2)	9,509,145	0	9,509,145	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of col. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,012,071	394,665	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTEREST	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,620,621	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,632,692	394,665	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of col. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	33,335	1,440,071	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTEREST	552,893	0	0	0	552,893	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,620,621	2.00
3.00	Total (sum of lines 1-2)	552,893	0	0	33,335	3,613,585	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151311

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

Worksheet A-8

Date/Time Prepared:
5/24/2014 10:35 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted					
			Cost Center		Line #	Wkst. A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
1.01 Investment income - CAP REL COSTS-BLDG & FIXT - INTEREST (chapter 2)	B	-396,399		CAP REL COSTS-BLDG & FIXT - INTEREST	1.01		11	1.01
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)			0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00		0	7.00
8.00 Television and radio service (chapter 21)			0		0.00		0	8.00
9.00 Parking lot (chapter 21)			0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-826,159					0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00		0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	2,109,507					0	12.00
13.00 Laundry and linen service			0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-75,888		CAFETERIA	11.00		0	14.00
15.00 Rental of quarters to employee and others			0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients	B	-189		CENTRAL SERVICES & SUPPLY	14.00		0	16.00
17.00 Sale of drugs to other than patients	B	-408,964		PHARMACY	15.00		0	17.00
18.00 Sale of medical records and abstracts	B	-9,242		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	993,844		CAP REL COSTS-BLDG & FIXT	1.00		9	26.00
26.01 Depreciation - CAP REL COSTS-BLDG & FIXT - INTEREST			0	CAP REL COSTS-BLDG & FIXT - INTEREST	1.01		0	26.01
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	407,689		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

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
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***		68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0 32.00
33.00 MISCELLANEOUS REVENUE	B	-821	OTHER ADMINSTRATIVE & GENERAL		5.06	0 33.00
33.01 MISCELLANEOUS REVENUE	B	349	OTHER ADMINSTRATIVE & GENERAL		5.06	0 33.01
33.02 LI FELINE RENTAL	B	-25	OTHER ADMINSTRATIVE & GENERAL		5.06	0 33.02
33.03 PURCHASE DISCOUNTS	B	-54,851	OTHER ADMINSTRATIVE & GENERAL		5.06	0 33.03
33.04 PHYSICAL THERAPY SALES	B	-1,426	PHYSICAL THERAPY		66.00	0 33.04
33.05 PACESETTER	B	-18,543	OTHER ADMINSTRATIVE & GENERAL		5.06	0 33.05
33.06 UPS POST XEROX	B	-132	OTHER ADMINSTRATIVE & GENERAL		5.06	0 33.06
33.07 DIETARY INCOME	B	-25,841	DIETARY		10.00	0 33.07
33.08 EDUCATION SERVICES	B	-244	NURSING ADMINSTRATION		13.00	0 33.08
33.09 CASH OVER/SHORT	B	266	OTHER ADMINSTRATIVE & GENERAL		5.06	0 33.09
33.10 PHYSICIAN RECRUITMENT	A	-14,429	OTHER ADMINSTRATIVE & GENERAL		5.06	0 33.10
33.11 MISC REVENUE - VENDING	B	-2,446	CAFETERIA		11.00	0 33.11
33.12 IHA AND AHA LOBBYING DUES	A	-3,133	OTHER ADMINSTRATIVE & GENERAL		5.06	0 33.12
33.13 CRNA EXPENSE - SALARY	A	-178,050	ANESTHESIOLOGY		53.00	0 33.13
33.14 CRNA EXPENSE - BENEFITS	A	-61,155	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.14
33.15 PATIENT PHONES - SALARY	A	0			0.00	0 33.15
33.16 PATIENT PHONES - BENEFITS	A	-5,039	COMMUNICATIONS		5.01	0 33.16
33.17 PATIENT PHONES - BENEFITS	A	-1,731	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.17
33.18		0			0.00	0 33.18
33.19 ASSISTED LIVING - BLDG DEPR	A	-154,382	CAP REL COSTS-BLDG & FIXT		1.00	9 33.19
33.20 ASSISTED LIVING - EQUIP DEPR	A	-1,544	CAP REL COSTS-MVBLE EQUIP		2.00	9 33.20
33.21 CAH HIT DEPRECIATION - PRE-2013	A	-181,354	CAP REL COSTS-MVBLE EQUIP		2.00	9 33.21
33.22 CAH HIT DEPRECIATION - 2013 ASSETS	A	-6,510	CAP REL COSTS-MVBLE EQUIP		2.00	9 33.22
33.23		0			0.00	0 33.23
33.24 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.24
33.25 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.25
33.26 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.26
33.27 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.27
33.28 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.28
33.29 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.29
33.30 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.30
33.31 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.31
33.32 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.32
33.33 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.33
33.34 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.34
33.35 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.35
33.36 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.36
33.37 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.37
33.38 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.38

Provider CCN: 151311

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

Worksheet A-8

Date/Time Prepared:
 5/24/2014 10:35 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
33.39 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.39
33.40 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.40
33.41 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.41
33.42 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.42
33.43 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.43
33.44 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.44
33.45 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.45
33.46 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.46
33.47 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.47
33.48 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.48
33.49 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.49
33.50 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.50
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,083,158					50.00

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

Provider CCN: 151311

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

Worksheet A-8-1

Date/Time Prepared: 5/24/2014 10:35 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION - BLD	125,406	0
2.00	1.01	CAP REL COSTS-BLDG & FIXT -	HOME OFFICE ALLOC - 3RD PART	938,587	936,310
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION - EQU	60,140	0
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION - EMP	351,020	0
4.01	5.02	PATIENT ACCOUNTING	HOME OFFICE ALLOCATION - REV	54,322	0
4.02	5.06	OTHER ADMINISTRATIVE & GENER	HOME OFFICE ALLOCATION - DAT	212,150	0
4.03	5.06	OTHER ADMINISTRATIVE & GENER	SERVICE LINE AGREEMENTS	682,744	682,744
4.04	5.06	OTHER ADMINISTRATIVE & GENER	HOME OFFICE ALLOCATION - OTH	1,023,826	0
4.05	7.00	OPERATION OF PLANT	HOME OFFICE ALLOCATION - MAI	5,740	0
4.06	7.00	OPERATION OF PLANT	HOME OFFICE ALLOCATION - PLA	233,053	0
4.07	9.00	HOUSEKEEPING	HOME OFFICE ALLOCATION - HOU	35,659	0
4.08	11.00	CAFETERIA	HOME OFFICE ALLOCATION - CAF	4,992	0
4.09	14.00	CENTRAL SERVICES & SUPPLY	HOME OFFICE ALLOCATION - PUR	922	0
4.10	66.00	PHYSICAL THERAPY	SERVICE LINE AGREEMENT	-3,079	-3,079
4.11	69.00	ELECTROCARDIOLOGY	SERVICE LINE AGREEMENT - SLE	1,500	1,500
4.12	73.02	ONCOLOGY	SERVICE LINE AGREEMENT	82,000	82,000
4.13	190.01	MARKETING/PUBLIC RELATIONS	SERVICE LINE AGREEMENT - MAR	26,657	26,657
4.14	192.00	PHYSICIANS' PRIVATE OFFICES	SERVICE LINE AGREEMENTS - PH	396,307	396,307
4.15	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.			4,231,946	2,122,439

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

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

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

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

6.00	B	IU HEALTH	100.00	IU HEALTH	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.

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

Provider CCN: 151311

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

Worksheet A-8-1

Date/Time Prepared:
5/24/2014 10:35 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	125,406	9		1.00
2.00	2,277	11		2.00
3.00	60,140	9		3.00
4.00	351,020	0		4.00
4.01	54,322	0		4.01
4.02	212,150	0		4.02
4.03	0	0		4.03
4.04	1,023,826	0		4.04
4.05	5,740	0		4.05
4.06	233,053	0		4.06
4.07	35,659	0		4.07
4.08	4,992	0		4.08
4.09	922	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
5.00	2,109,507			5.00

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

Related Organization(s) and/or Home Office	Type of Business		
	6.00		
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:			

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

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

6.00	HEALTHCARE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151311

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

Worksheet A-8-2

Date/Time Prepared:
5/24/2014 10:35 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	200,012	139,772	60,240	0	0	1.00
2.00	67.00	OCCUPATIONAL THERAPY	5,000	0	5,000	0	0	2.00
3.00	91.00	EMERGENCY	1,327,840	686,387	641,453	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,532,852	826,159	706,693			200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	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	60.00	LABORATORY	0	0	0	139,772	1.00
2.00	67.00	OCCUPATIONAL THERAPY	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	686,387	3.00
4.00	0.00		0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	826,159	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151311

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

Worksheet B
Part I
Date/Time Prepared:
5/24/2014 10:35 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	BLDG & FIXT - INTEREST	MVBLE EQUIP		
	0	1.00	1.01	2.00	4.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,440,071	1,440,071			1.00
1.01 00101	CAP REL COSTS-BLDG & FIXT - INTEREST	552,893	0	552,893		1.01
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,620,621			1,620,621	2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	4,718,530	0	0	0	4,718,530
5.01 00510	COMMUNICATIONS	460,485	13,495	7,562	18,894	112,585
5.02 00520	PATIENT ACCOUNTING	720,086	18,340	10,276	25,677	88,995
5.06 00560	OTHER ADMINISTRATIVE & GENERAL	5,353,559	58,228	32,627	81,524	422,189
7.00 00700	OPERATION OF PLANT	2,476,336	211,484	101,344	296,097	8,224
7.01 00701	OPERATION OF PLANT - OFFSITE	0	0	0	0	0
8.00 00800	LAUNDRY & LINEN SERVICE	79,909	15,956	8,941	22,340	0
9.00 00900	HOUSEKEEPING	356,675	16,870	9,453	23,620	103,920
10.00 01000	DIETARY	364,219	30,750	17,230	43,052	79,723
11.00 01100	CAFETERIA	165,591	13,168	7,378	18,436	48,528
13.00 01300	NURSING ADMINISTRATION	412,982	33,517	15,953	46,927	134,494
14.00 01400	CENTRAL SERVICES & SUPPLY	577,156	26,175	14,667	36,647	37,903
15.00 01500	PHARMACY	267,833	7,976	4,469	11,167	169,310
16.00 01600	MEDICAL RECORDS & LIBRARY	388,011	19,975	11,193	27,967	75,680
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,658,327	79,637	44,623	111,498	542,025
31.00 03100	INTENSIVE CARE UNIT	634,065	20,941	11,734	29,319	209,554
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,265,104	120,850	67,715	169,199	402,248
53.00 05300	ANESTHESIOLOGY	494,897	2,217	1,242	3,104	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,230,292	59,147	33,142	82,811	292,811
60.00 06000	LABORATORY	1,222,356	25,428	14,248	35,601	266,687
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	392,650	1,485	832	2,079	119,331
66.00 06600	PHYSICAL THERAPY	735,505	57,808	32,391	80,935	215,883
67.00 06700	OCCUPATIONAL THERAPY	316,250	2,051	1,149	2,872	98,092
69.00 06900	ELECTROCARDIOLOGY	393,353	48,248	27,035	67,552	85,438
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,861,347	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	1,269,469	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	1,898,545	0	0	0	0
73.02 07302	ONCOLOGY	242,499	9,861	5,525	13,805	75,849
76.97 07697	CARDIAC REHABILITATION	53,033	9,128	5,115	12,780	17,514
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0
91.00 09100	EMERGENCY	1,430,936	59,584	33,386	83,422	441,036
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
92.01 09201	OBSERVATION BEDS (DISTINCT PART)	481,587	12,223	6,849	17,113	159,158
OTHER REIMBURSABLE COST CENTERS						
98.00 05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	35,535,172	974,542	526,079	1,364,438	4,207,177
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
190.01 19001	MARKETING/PUBLIC RELATIONS	90,276	6,397	3,584	8,956	5,407
190.02 19002	HEALTH MINISTRY	1,064	0	0	0	352
191.00 19100	RESEARCH	0	0	0	0	0
191.04 19104	MEALS ON WHEELS	0	0	0	0	0
191.06 19106	ASSISTED LIVING	35,771	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	5,211,747	169,389	15,749	237,158	416,690
192.01 19201	OCCUPATIONAL MEDICINE	67,930	7,192	4,030	10,069	14,519
192.02 19202	MEDICAL NETWORK	351,918	0	0	0	60,910
193.00 19300	NONPAID WORKERS	0	0	0	0	0
193.01 19301	IUH HOME HEALTH AGENCY	0	10,323	0	0	0
194.00 07950	COMMUNITY FITNESS	65,698	0	0	0	13,475
194.01 07951	VACANT SPACE	0	272,228	3,451	0	0
194.04 07954	FOUNDATION	36,602	0	0	0	0
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	41,396,178	1,440,071	552,893	1,620,621	4,718,530

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 151311		Period: From 01/01/2013 To 12/31/2013		Worksheet B Part I Date/Time Prepared: 5/24/2014 10:35 am	
Cost Center Description		COMMUNICATIONS	PATIENT ACCOUNTING	OTHER ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - OFFSITE	
		5.01	5.02	5.06	7.00	7.01	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.01	00510	613,021					5.01
5.02	00520	5,971	869,345				5.02
5.06	00560	59,710	0	6,007,837			5.06
7.00	00700	47,768	0	532,075	3,673,328		7.00
7.01	00701	0	0	0	151,942	151,942	7.01
8.00	00800	0	0	21,459	79,179	0	8.00
9.00	00900	0	0	86,662	83,714	0	9.00
10.00	01000	31,845	0	96,082	152,586	0	10.00
11.00	01100	13,932	0	45,279	65,343	0	11.00
13.00	01300	39,807	0	115,928	141,275	4,895	13.00
14.00	01400	7,961	0	118,876	129,886	0	14.00
15.00	01500	7,961	0	79,640	39,577	0	15.00
16.00	01600	33,836	0	94,467	99,122	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	29,855	26,983	422,801	395,173	0	30.00
31.00	03100	17,913	5,474	157,714	103,914	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	57,720	156,412	377,330	599,675	0	50.00
53.00	05300	0	53,669	93,622	11,002	0	53.00
54.00	05400	25,874	166,679	318,551	293,500	0	54.00
60.00	06000	29,855	93,395	285,417	126,176	0	60.00
64.00	06400	0	10,241	1,593	0	0	64.00
65.00	06500	7,961	17,091	91,829	7,369	0	65.00
66.00	06600	15,923	28,565	198,152	286,853	0	66.00
67.00	06700	31,845	9,576	77,374	10,178	0	67.00
69.00	06900	29,855	38,251	113,631	239,418	0	69.00
71.00	07100	0	46,378	323,821	0	0	71.00
72.00	07200	0	36,774	221,652	0	0	72.00
73.00	07300	0	82,102	335,707	0	0	73.00
73.02	07302	13,932	6,529	62,393	48,930	0	73.02
76.97	07697	0	1,714	19,386	45,297	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	17,913	84,283	363,945	295,665	0	91.00
92.00	09200						92.00
92.01	09201	5,971	5,229	116,842	60,653	0	92.01
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		533,408	869,345	4,772,228	3,466,427	4,895	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	1,990	0	338	0	0	190.00
190.01	19001	5,971	0	20,443	31,744	0	190.01
190.02	19002	0	0	241	0	0	190.02
191.00	19100	0	0	0	0	0	191.00
191.04	19104	0	0	0	0	0	191.04
191.06	19106	0	0	6,084	0	0	191.06
192.00	19200	63,691	0	1,052,373	139,471	137,035	192.00
192.01	19201	7,961	0	17,570	35,686	0	192.01
192.02	19202	0	0	70,220	0	0	192.02
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	1,756	0	10,012	193.01
194.00	07950	0	0	13,467	0	0	194.00
194.01	07951	0	0	46,891	0	0	194.01
194.04	07954	0	0	6,226	0	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		613,021	869,345	6,007,837	3,673,328	151,942	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151311

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTEREST					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	COMMUNICATIONS					5.01
5.02	00520	PATIENT ACCOUNTING					5.02
5.06	00560	OTHER ADMINISTRATIVE & GENERAL					5.06
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT - OFFSITE					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	227,784				8.00
9.00	00900	HOUSEKEEPING	0	680,914			9.00
10.00	01000	DIETARY	0	28,548	844,035		10.00
11.00	01100	CAFETERIA	0	12,225	0	389,880	11.00
13.00	01300	NURSING ADMINISTRATION	0	31,117	0	8,503	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	24,301	0	6,318	14.00
15.00	01500	PHARMACY	0	7,404	0	14,362	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	18,545	0	16,452	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	85,319	73,933	686,564	70,509	30.00
31.00	03100	INTENSIVE CARE UNIT	14,197	19,441	93,796	21,645	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	39,611	112,195	0	37,748	50.00
53.00	05300	ANESTHESIOLOGY	0	2,058	0	1,979	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,347	54,911	0	29,689	54.00
60.00	06000	LABORATORY	324	23,606	0	34,027	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	339	1,379	0	13,221	65.00
66.00	06600	PHYSICAL THERAPY	9,774	53,668	0	26,834	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,904	0	7,841	67.00
69.00	06900	ELECTROCARDIOLOGY	7,603	44,793	0	11,306	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.02	07302	ONCOLOGY	712	9,154	0	5,213	73.02
76.97	07697	CARDIAC REHABILITATION	0	8,475	0	1,615	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	28,628	55,316	0	35,532	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	8,466	11,348	0	22,484	92.01
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	216,320	594,321	780,360	365,278	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	0	5,939	0	950	190.01
190.02	19002	HEALTH MINISTRY	0	0	0	32	190.02
191.00	19100	RESEARCH	0	0	0	0	191.00
191.04	19104	MEALS ON WHEELS	0	0	63,675	0	191.04
191.06	19106	ASSISTED LIVING	0	0	0	0	191.06
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,856	64,394	0	17,878	192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	6,677	0	2,296	192.01
192.02	19202	MEDICAL NETWORK	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	IUH HOME HEALTH AGENCY	0	9,583	0	0	193.01
194.00	07950	COMMUNITY FITNESS	6,608	0	0	3,446	194.00
194.01	07951	VACANT SPACE	0	0	0	0	194.01
194.04	07954	FOUNDATION	0	0	0	0	194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	227,784	680,914	844,035	389,880	985,398

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151311

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

Worksheet B
Part I
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Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	15.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTEREST					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	COMMUNICATIONS					5.01
5.02	00520	PATIENT ACCOUNTING					5.02
5.06	00560	OTHER ADMINISTRATIVE & GENERAL					5.06
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT - OFFSITE					7.01
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	979,890				14.00
15.00	01500	PHARMACY	5,064	614,763			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,168	0	786,416		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,479	0	24,409	4,545,055	0 30.00
31.00	03100	INTENSIVE CARE UNIT	292	0	4,951	1,433,787	0 31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,078	0	141,490	3,710,887	0 50.00
53.00	05300	ANESTHESIOLOGY	0	0	48,549	720,466	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,675	0	150,784	2,883,200	0 54.00
60.00	06000	LABORATORY	2,492	0	84,485	2,244,097	0 60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	9,264	21,098	0 64.00
65.00	06500	RESPIRATORY THERAPY	10,107	0	15,461	681,134	0 65.00
66.00	06600	PHYSICAL THERAPY	1,068	0	25,840	1,769,199	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	64	0	8,662	567,858	0 67.00
69.00	06900	ELECTROCARDIOLOGY	2,806	0	34,602	1,188,886	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	550,206	0	41,954	2,823,706	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	392,069	0	33,266	1,953,230	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	614,763	74,269	3,005,386	0 73.00
73.02	07302	ONCOLOGY	517	0	5,907	522,265	0 73.02
76.97	07697	CARDIAC REHABILITATION	125	0	1,551	182,456	0 76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	1,432	0	76,242	3,154,015	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	280	0	4,730	1,006,096	0 92.01
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0 98.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	972,922	614,763	786,416	32,412,821	0 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	2,328	0 190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	1,435	0	0	181,102	0 190.01
190.02	19002	HEALTH MINISTRY	0	0	0	1,689	0 190.02
191.00	19100	RESEARCH	0	0	0	0	0 191.00
191.04	19104	MEALS ON WHEELS	0	0	0	63,675	0 191.04
191.06	19106	ASSISTED LIVING	109	0	0	41,964	0 191.06
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,995	0	0	7,533,426	0 192.00
192.01	19201	OCCUPATIONAL MEDICINE	466	0	0	174,396	0 192.01
192.02	19202	MEDICAL NETWORK	1,290	0	0	484,338	0 192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0 193.00
193.01	19301	IUH HOME HEALTH AGENCY	0	0	0	31,674	0 193.01
194.00	07950	COMMUNITY FITNESS	673	0	0	103,367	0 194.00
194.01	07951	VACANT SPACE	0	0	0	322,570	0 194.01
194.04	07954	FOUNDATION	0	0	0	42,828	0 194.04
200.00		Cross Foot Adjustments				0	0 200.00
201.00		Negative Cost Centers	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118-201)	979,890	614,763	786,416	41,396,178	0 202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 151311	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part I Date/Time Prepared: 5/24/2014 10:35 am
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTEREST	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00510	COMMUNICATIONS	5.01
5.02	00520	PATIENT ACCOUNTING	5.02
5.06	00560	OTHER ADMINISTRATIVE & GENERAL	5.06
7.00	00700	OPERATION OF PLANT	7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	7.01
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
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
73.02	07302	ONCOLOGY	73.02
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	92.01
OTHER REIMBURSABLE COST CENTERS			
98.00	05950	OTHER REIMBURSABLE COST CENTERS	98.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	190.01
190.02	19002	HEALTH MINISTRY	190.02
191.00	19100	RESEARCH	191.00
191.04	19104	MEALS ON WHEELS	191.04
191.06	19106	ASSISTED LIVING	191.06
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	OCCUPATIONAL MEDICINE	192.01
192.02	19202	MEDICAL NETWORK	192.02
193.00	19300	NONPAID WORKERS	193.00
193.01	19301	IUH HOME HEALTH AGENCY	193.01
194.00	07950	COMMUNITY FITNESS	194.00
194.01	07951	VACANT SPACE	194.01
194.04	07954	FOUNDATION	194.04
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151311	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 5/24/2014 10:35 am
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
		BLDG & FIXT	BLDG & FIXT - INTEREST	MVBLE EQUIP		
		0	1.00	1.01		
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	CAP REL COSTS-BLDG & FIXT - INTEREST					1.01
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.01 00510	COMMUNICATIONS	0	13,495	7,562	18,894	39,951
5.02 00520	PATIENT ACCOUNTING	0	18,340	10,276	25,677	54,293
5.06 00560	OTHER ADMINISTRATIVE & GENERAL	0	58,228	32,627	81,524	172,379
7.00 00700	OPERATION OF PLANT	0	211,484	101,344	296,097	608,925
7.01 00701	OPERATION OF PLANT - OFFSITE	0	0	0	0	0
8.00 00800	LAUNDRY & LINEN SERVICE	0	15,956	8,941	22,340	47,237
9.00 00900	HOUSEKEEPING	0	16,870	9,453	23,620	49,943
10.00 01000	DIETARY	0	30,750	17,230	43,052	91,032
11.00 01100	CAFETERIA	0	13,168	7,378	18,436	38,982
13.00 01300	NURSING ADMINISTRATION	0	33,517	15,953	46,927	96,397
14.00 01400	CENTRAL SERVICES & SUPPLY	0	26,175	14,667	36,647	77,489
15.00 01500	PHARMACY	0	7,976	4,469	11,167	23,612
16.00 01600	MEDICAL RECORDS & LIBRARY	0	19,975	11,193	27,967	59,135
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	79,637	44,623	111,498	235,758
31.00 03100	INTENSIVE CARE UNIT	0	20,941	11,734	29,319	61,994
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	120,850	67,715	169,199	357,764
53.00 05300	ANESTHESIOLOGY	0	2,217	1,242	3,104	6,563
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	59,147	33,142	82,811	175,100
60.00 06000	LABORATORY	0	25,428	14,248	35,601	75,277
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	0	1,485	832	2,079	4,396
66.00 06600	PHYSICAL THERAPY	0	57,808	32,391	80,935	171,134
67.00 06700	OCCUPATIONAL THERAPY	0	2,051	1,149	2,872	6,072
69.00 06900	ELECTROCARDIOLOGY	0	48,248	27,035	67,552	142,835
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
73.02 07302	ONCOLOGY	0	9,861	5,525	13,805	29,191
76.97 07697	CARDIAC REHABILITATION	0	9,128	5,115	12,780	27,023
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0
91.00 09100	EMERGENCY	0	59,584	33,386	83,422	176,392
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
92.01 09201	OBSERVATION BEDS (DISTINCT PART)	0	12,223	6,849	17,113	36,185
OTHER REIMBURSABLE COST CENTERS						
98.00 05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	974,542	526,079	1,364,438	2,865,059
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
190.01 19001	MARKETING/PUBLIC RELATIONS	0	6,397	3,584	8,956	18,937
190.02 19002	HEALTH MINISTRY	0	0	0	0	0
191.00 19100	RESEARCH	0	0	0	0	0
191.04 19104	MEALS ON WHEELS	0	0	0	0	0
191.06 19106	ASSISTED LIVING	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	169,389	15,749	237,158	422,296
192.01 19201	OCCUPATIONAL MEDICINE	0	7,192	4,030	10,069	21,291
192.02 19202	MEDICAL NETWORK	0	0	0	0	0
193.00 19300	NONPAID WORKERS	0	0	0	0	0
193.01 19301	IUH HOME HEALTH AGENCY	0	10,323	0	0	10,323
194.00 07950	COMMUNITY FITNESS	0	0	0	0	0
194.01 07951	VACANT SPACE	0	272,228	3,451	0	275,679
194.04 07954	FOUNDATION	0	0	0	0	0
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	0	1,440,071	552,893	1,620,621	3,613,585

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 151311	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 5/24/2014 10:35 am		
Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT 4.00	COMMUNICATIONS 5.01	PATIENT ACCOUNTING 5.02	OTHER ADMINISTRATIVE & GENERAL 5.06	OPERATION OF PLANT 7.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTEREST					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0				4.00
5.01	00510	COMMUNICATIONS	0	39,951			5.01
5.02	00520	PATIENT ACCOUNTING	0	389	54,682		5.02
5.06	00560	OTHER ADMINISTRATIVE & GENERAL	0	3,891	0	176,270	5.06
7.00	00700	OPERATION OF PLANT	0	3,113	0	15,612	627,650
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	0	0	25,962
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	630	13,529
9.00	00900	HOUSEKEEPING	0	0	0	2,543	14,304
10.00	01000	DIETARY	0	2,075	0	2,819	26,072
11.00	01100	CAFETERIA	0	908	0	1,329	11,165
13.00	01300	NURSING ADMINISTRATION	0	2,594	0	3,402	24,139
14.00	01400	CENTRAL SERVICES & SUPPLY	0	519	0	3,488	22,193
15.00	01500	PHARMACY	0	519	0	2,337	6,762
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,205	0	2,772	16,937
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,946	1,697	12,406	67,522
31.00	03100	INTENSIVE CARE UNIT	0	1,167	344	4,628	17,755
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	3,762	9,835	11,072	102,465
53.00	05300	ANESTHESIOLOGY	0	0	3,375	2,747	1,880
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,686	10,500	9,347	50,149
60.00	06000	LABORATORY	0	1,946	5,872	8,375	21,559
64.00	06400	INTRAVENOUS THERAPY	0	0	644	47	0
65.00	06500	RESPIRATORY THERAPY	0	519	1,075	2,694	1,259
66.00	06600	PHYSICAL THERAPY	0	1,038	1,796	5,814	49,014
67.00	06700	OCCUPATIONAL THERAPY	0	2,075	602	2,270	1,739
69.00	06900	ELECTROCARDIOLOGY	0	1,946	2,405	3,334	40,909
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,916	9,502	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,312	6,504	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	5,162	9,850	0
73.02	07302	ONCOLOGY	0	908	411	1,831	8,360
76.97	07697	CARDIAC REHABILITATION	0	0	108	569	7,740
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	1,167	5,299	10,679	50,519
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0				
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	389	329	3,428	10,364
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	34,762	54,682	140,029	592,297
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	130	0	10	0
190.01	19001	MARKETING/PUBLIC RELATIONS	0	389	0	600	5,424
190.02	19002	HEALTH MINISTRY	0	0	0	7	0
191.00	19100	RESEARCH	0	0	0	0	0
191.04	19104	MEALS ON WHEELS	0	0	0	0	0
191.06	19106	ASSISTED LIVING	0	0	0	179	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,151	0	30,863	23,831
192.01	19201	OCCUPATIONAL MEDICINE	0	519	0	516	6,098
192.02	19202	MEDICAL NETWORK	0	0	0	2,060	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	IUH HOME HEALTH AGENCY	0	0	0	52	0
194.00	07950	COMMUNITY FITNESS	0	0	0	395	0
194.01	07951	VACANT SPACE	0	0	0	1,376	0
194.04	07954	FOUNDATION	0	0	0	183	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	0	39,951	54,682	176,270	627,650

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151311		Period: From 01/01/2013 To 12/31/2013		Worksheet B Part II Date/Time Prepared: 5/24/2014 10:35 am	
Cost Center Description		OPERATION OF PLANT - OFFSITE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.01	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTEREST					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	COMMUNICATIONS					5.01
5.02	00520	PATIENT ACCOUNTING					5.02
5.06	00560	OTHER ADMINISTRATIVE & GENERAL					5.06
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	25,962				7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	61,396			8.00
9.00	00900	HOUSEKEEPING	0	0	66,790		9.00
10.00	01000	DIETARY	0	0	2,800	124,798	10.00
11.00	01100	CAFETERIA	0	0	1,199	0	53,583
13.00	01300	NURSING ADMINISTRATION	836	0	3,052	0	1,169
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	2,384	0	868
15.00	01500	PHARMACY	0	0	726	0	1,974
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,819	0	2,261
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	22,996	7,252	101,514	9,689
31.00	03100	INTENSIVE CARE UNIT	0	3,827	1,907	13,869	2,975
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	10,677	11,005	0	5,188
53.00	05300	ANESTHESIOLOGY	0	0	202	0	272
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,754	5,386	0	4,080
60.00	06000	LABORATORY	0	87	2,316	0	4,677
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	91	135	0	1,817
66.00	06600	PHYSICAL THERAPY	0	2,635	5,264	0	3,688
67.00	06700	OCCUPATIONAL THERAPY	0	0	187	0	1,078
69.00	06900	ELECTROCARDIOLOGY	0	2,049	4,394	0	1,554
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
73.02	07302	ONCOLOGY	0	192	898	0	716
76.97	07697	CARDIAC REHABILITATION	0	0	831	0	222
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	7,716	5,426	0	4,883
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	2,282	1,113	0	3,090
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	836	58,306	58,296	115,383	50,201
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
190.01	19001	MARKETING/PUBLIC RELATIONS	0	0	583	0	131
190.02	19002	HEALTH MINISTRY	0	0	0	0	4
191.00	19100	RESEARCH	0	0	0	0	0
191.04	19104	MEALS ON WHEELS	0	0	0	9,415	0
191.06	19106	ASSISTED LIVING	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	23,415	1,309	6,316	0	2,457
192.01	19201	OCCUPATIONAL MEDICINE	0	0	655	0	316
192.02	19202	MEDICAL NETWORK	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	IUH HOME HEALTH AGENCY	1,711	0	940	0	0
194.00	07950	COMMUNITY FITNESS	0	1,781	0	0	474
194.01	07951	VACANT SPACE	0	0	0	0	0
194.04	07954	FOUNDATION	0	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)	25,962	61,396	66,790	124,798	53,583

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151311		Period: From 01/01/2013 To 12/31/2013		Worksheet B Part II Date/Time Prepared: 5/24/2014 10:35 am	
Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00520						5.02
5.06	00560						5.06
7.00	00700						7.00
7.01	00701						7.01
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	131,589					13.00
14.00	01400	0	106,941				14.00
15.00	01500	0	553	36,483			15.00
16.00	01600	0	128	0	85,257		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	38,982	161	0	2,646	502,569	30.00
31.00	03100	11,863	32	0	537	120,898	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	21,568	227	0	15,340	548,903	50.00
53.00	05300	1,085	0	0	5,263	21,387	53.00
54.00	05400	16,290	183	0	16,347	294,822	54.00
60.00	06000	0	272	0	9,159	129,540	60.00
64.00	06400	0	0	0	1,004	1,695	64.00
65.00	06500	0	1,103	0	1,676	14,765	65.00
66.00	06600	0	117	0	2,801	243,301	66.00
67.00	06700	0	7	0	939	14,969	67.00
69.00	06900	6,009	306	0	3,751	209,492	69.00
71.00	07100	0	60,045	0	4,548	77,011	71.00
72.00	07200	0	42,789	0	3,607	55,212	72.00
73.00	07300	0	0	36,483	8,052	59,547	73.00
73.02	07302	2,863	56	0	640	46,066	73.02
76.97	07697	898	14	0	168	37,573	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	19,590	156	0	8,266	290,093	91.00
92.00	09200						92.00
92.01	09201	12,441	31	0	513	70,165	92.01
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		131,589	106,180	36,483	85,257	2,738,008	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	140	190.00
190.01	19001	0	157	0	0	26,221	190.01
190.02	19002	0	0	0	0	11	190.02
191.00	19100	0	0	0	0	0	191.00
191.04	19104	0	0	0	0	9,415	191.04
191.06	19106	0	12	0	0	191	191.06
192.00	19200	0	327	0	0	514,965	192.00
192.01	19201	0	51	0	0	29,446	192.01
192.02	19202	0	141	0	0	2,201	192.02
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	13,026	193.01
194.00	07950	0	73	0	0	2,723	194.00
194.01	07951	0	0	0	0	277,055	194.01
194.04	07954	0	0	0	0	183	194.04
200.00						0	200.00
201.00		0	0	0	0	0	201.00
202.00		131,589	106,941	36,483	85,257	3,613,585	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151311	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 5/24/2014 10:35 am
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTEREST		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00510	COMMUNICATIONS		5.01
5.02	00520	PATIENT ACCOUNTING		5.02
5.06	00560	OTHER ADMINISTRATIVE & GENERAL		5.06
7.00	00700	OPERATION OF PLANT		7.00
7.01	00701	OPERATION OF PLANT - OFFSITE		7.01
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
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	502,569
31.00	03100	INTENSIVE CARE UNIT	0	120,898
ALLIARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	548,903
53.00	05300	ANESTHESIOLOGY	0	21,387
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	294,822
60.00	06000	LABORATORY	0	129,540
64.00	06400	INTRAVENOUS THERAPY	0	1,695
65.00	06500	RESPIRATORY THERAPY	0	14,765
66.00	06600	PHYSICAL THERAPY	0	243,301
67.00	06700	OCCUPATIONAL THERAPY	0	14,969
69.00	06900	ELECTROCARDIOLOGY	0	209,492
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	77,011
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	55,212
73.00	07300	DRUGS CHARGED TO PATIENTS	0	59,547
73.02	07302	ONCOLOGY	0	46,066
76.97	07697	CARDIAC REHABILITATION	0	37,573
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0
91.00	09100	EMERGENCY	0	290,093
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	70,165
OTHER REIMBURSABLE COST CENTERS				
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,738,008
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	140
190.01	19001	MARKETING/PUBLIC RELATIONS	0	26,221
190.02	19002	HEALTH MINISTRY	0	11
191.00	19100	RESEARCH	0	0
191.04	19104	MEALS ON WHEELS	0	9,415
191.06	19106	ASSISTED LIVING	0	191
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	514,965
192.01	19201	OCCUPATIONAL MEDICINE	0	29,446
192.02	19202	MEDICAL NETWORK	0	2,201
193.00	19300	NONPAID WORKERS	0	0
193.01	19301	IUH HOME HEALTH AGENCY	0	13,026
194.00	07950	COMMUNITY FITNESS	0	2,723
194.01	07951	VACANT SPACE	0	277,055
194.04	07954	FOUNDATION	0	183
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	3,613,585

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151311

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

Worksheet B-1

Date/Time Prepared:
5/24/2014 10:35 am

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NONPATIENT TELEPHONES)	
		BLDG & FIXT (SQUARE FEET)	BLDG & FIXT - INTEREST (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)			
		1.00	1.01	2.00			
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	277,338				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTEREST	0	190,031			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			222,923		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	14,262,039	4.00
5.01	00510	COMMUNICATIONS	2,599	2,599	2,599	340,294	308 5.01
5.02	00520	PATIENT ACCOUNTING	3,532	3,532	3,532	268,992	3 5.02
5.06	00560	OTHER ADMINISTRATIVE & GENERAL	11,214	11,214	11,214	1,276,093	30 5.06
7.00	00700	OPERATION OF PLANT	40,729	34,832	40,729	24,859	24 7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	0	0	0 7.01
8.00	00800	LAUNDRY & LINEN SERVICE	3,073	3,073	3,073	0	0 8.00
9.00	00900	HOUSEKEEPING	3,249	3,249	3,249	314,105	0 9.00
10.00	01000	DIETARY	5,922	5,922	5,922	240,967	16 10.00
11.00	01100	CAFETERIA	2,536	2,536	2,536	146,680	7 11.00
13.00	01300	NURSING ADMINISTRATION	6,455	5,483	6,455	406,518	20 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,041	5,041	5,041	114,563	4 14.00
15.00	01500	PHARMACY	1,536	1,536	1,536	511,750	4 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,847	3,847	3,847	228,749	17 16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	15,337	15,337	15,337	1,638,289	15 30.00
31.00	03100	INTENSIVE CARE UNIT	4,033	4,033	4,033	633,391	9 31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	23,274	23,274	23,274	1,215,820	29 50.00
53.00	05300	ANESTHESIOLOGY	427	427	427	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,391	11,391	11,391	885,041	13 54.00
60.00	06000	LABORATORY	4,897	4,897	4,897	806,077	15 60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	286	286	286	360,686	4 65.00
66.00	06600	PHYSICAL THERAPY	11,133	11,133	11,133	652,520	8 66.00
67.00	06700	OCCUPATIONAL THERAPY	395	395	395	296,489	16 67.00
69.00	06900	ELECTROCARDIOLOGY	9,292	9,292	9,292	258,241	15 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
73.02	07302	ONCOLOGY	1,899	1,899	1,899	229,257	7 73.02
76.97	07697	CARDIAC REHABILITATION	1,758	1,758	1,758	52,938	0 76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	11,475	11,475	11,475	1,333,058	9 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	2,354	2,354	2,354	481,066	3 92.01
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0 98.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	187,684	180,815	187,684	12,716,443	268 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	1 190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	1,232	1,232	1,232	16,342	3 190.01
190.02	19002	HEALTH MINISTRY	0	0	0	1,064	0 190.02
191.00	19100	RESEARCH	0	0	0	0	0 191.00
191.04	19104	MEALS ON WHEELS	0	0	0	0	0 191.04
191.06	19106	ASSISTED LIVING	0	0	0	0	0 191.06
192.00	19200	PHYSICIANS' PRIVATE OFFICES	32,622	5,413	32,622	1,259,473	32 192.00
192.01	19201	OCCUPATIONAL MEDICINE	1,385	1,385	1,385	43,885	4 192.01
192.02	19202	MEDICAL NETWORK	0	0	0	184,104	0 192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0 193.00
193.01	19301	IUH HOME HEALTH AGENCY	1,988	0	0	0	0 193.01
194.00	07950	COMMUNITY FITNESS	0	0	0	40,728	0 194.00
194.01	07951	VACANT SPACE	52,427	1,186	0	0	0 194.01
194.04	07954	FOUNDATION	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)	1,440,071	552,893	1,620,621	4,718,530	613,021 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.192476	2.909488	7.269869	0.330845	1,990.327922 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0	39,951 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000	129.711039 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151311

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

Worksheet B-1

Date/Time Prepared:
5/24/2014 10:35 am

Cost Center Description		PATIENT ACCOUNTING (GROSS REVENUES)	OTHER ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT - OFFSITE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		5.02	5.06	7.00	7.01	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00520						5.02
5.06	00560	85,942,436					5.06
7.00	00700						7.00
7.01	00701						7.01
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500						15.00
16.00	01600						16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000						30.00
31.00	03100						31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000						50.00
53.00	05300						53.00
54.00	05400						54.00
60.00	06000						60.00
64.00	06400						64.00
65.00	06500						65.00
66.00	06600						66.00
67.00	06700						67.00
69.00	06900						69.00
71.00	07100						71.00
72.00	07200						72.00
73.00	07300						73.00
73.02	07302						73.02
76.97	07697						76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000						90.00
91.00	09100						91.00
92.00	09200						92.00
92.01	09201						92.01
OTHER REIMBURSABLE COST CENTERS							
98.00	05950						98.00
SPECIAL PURPOSE COST CENTERS							
118.00							118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000						190.00
190.01	19001						190.01
190.02	19002						190.02
191.00	19100						191.00
191.04	19104						191.04
191.06	19106						191.06
192.00	19200						192.00
192.01	19201						192.01
192.02	19202						192.02
193.00	19300						193.00
193.01	19301						193.01
194.00	07950						194.00
194.01	07951						194.01
194.04	07954						194.04
200.00							200.00
201.00							201.00
202.00							202.00
203.00							203.00
204.00							204.00
205.00							205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151311

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

Worksheet B-1
Date/Time Prepared:
5/24/2014 10:35 am

Cost Center Description		HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00520						5.02
5.06	00560						5.06
7.00	00700						7.00
7.01	00701						7.01
8.00	00800						8.00
9.00	00900	141,251					9.00
10.00	01000	5,922	19,419				10.00
11.00	01100	2,536	0	246,228			11.00
13.00	01300	6,455	0	5,370	235,099		13.00
14.00	01400	5,041	0	3,990	0	3,172,757	14.00
15.00	01500	1,536	0	9,070	0	16,397	15.00
16.00	01600	3,847	0	10,390	0	3,783	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	15,337	15,796	44,530	69,647	4,789	30.00
31.00	03100	4,033	2,158	13,670	21,195	947	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	23,274	0	23,840	38,534	6,729	50.00
53.00	05300	427	0	1,250	1,939	0	53.00
54.00	05400	11,391	0	18,750	29,104	5,423	54.00
60.00	06000	4,897	0	21,490	0	8,069	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	286	0	8,350	0	32,726	65.00
66.00	06600	11,133	0	16,947	0	3,458	66.00
67.00	06700	395	0	4,952	0	206	67.00
69.00	06900	9,292	0	7,140	10,735	9,086	69.00
71.00	07100	0	0	0	0	1,781,494	71.00
72.00	07200	0	0	0	0	1,269,469	72.00
73.00	07300	0	0	0	0	0	73.00
73.02	07302	1,899	0	3,292	5,115	1,673	73.02
76.97	07697	1,758	0	1,020	1,604	404	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	11,475	0	22,440	34,999	4,636	91.00
92.00	09200						92.00
92.01	09201	2,354	0	14,200	22,227	907	92.01
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		123,288	17,954	230,691	235,099	3,150,196	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	1,232	0	600	0	4,646	190.01
190.02	19002	0	0	20	0	0	190.02
191.00	19100	0	0	0	0	0	191.00
191.04	19104	0	1,465	0	0	0	191.04
191.06	19106	0	0	0	0	352	191.06
192.00	19200	13,358	0	11,291	0	9,697	192.00
192.01	19201	1,385	0	1,450	0	1,510	192.01
192.02	19202	0	0	0	0	4,178	192.02
193.00	19300	0	0	0	0	0	193.00
193.01	19301	1,988	0	0	0	0	193.01
194.00	07950	0	0	2,176	0	2,178	194.00
194.01	07951	0	0	0	0	0	194.01
194.04	07954	0	0	0	0	0	194.04
200.00							200.00
201.00							201.00
202.00		680,914	844,035	389,880	985,398	979,890	202.00
203.00		4.820596	43.464391	1.583410	4.191417	0.308845	203.00
204.00		66,790	124,798	53,583	131,589	106,941	204.00
205.00		0.472846	6.426593	0.217615	0.559717	0.033706	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151311

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

Worksheet B-1
Date/Time Prepared:
5/24/2014 10:35 am

Cost Center Description		PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUES)	
		15.00	16.00	
GENERAL SERVICE COST CENTERS				
1.00	00100			1.00
1.01	00101			1.01
2.00	00200			2.00
4.00	00400			4.00
5.01	00510			5.01
5.02	00520			5.02
5.06	00560			5.06
7.00	00700			7.00
7.01	00701			7.01
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	100	85,942,436	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000			30.00
31.00	03100			31.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000			50.00
53.00	05300			53.00
54.00	05400			54.00
60.00	06000			60.00
64.00	06400			64.00
65.00	06500			65.00
66.00	06600			66.00
67.00	06700			67.00
69.00	06900			69.00
71.00	07100			71.00
72.00	07200			72.00
73.00	07300			73.00
73.02	07302			73.02
76.97	07697			76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000			90.00
91.00	09100			91.00
92.00	09200			92.00
92.01	09201			92.01
OTHER REIMBURSABLE COST CENTERS				
98.00	05950			98.00
SPECIAL PURPOSE COST CENTERS				
118.00		100	85,942,436	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000			190.00
190.01	19001			190.01
190.02	19002			190.02
191.00	19100			191.00
191.04	19104			191.04
191.06	19106			191.06
192.00	19200			192.00
192.01	19201			192.01
192.02	19202			192.02
193.00	19300			193.00
193.01	19301			193.01
194.00	07950			194.00
194.01	07951			194.01
194.04	07954			194.04
200.00				200.00
201.00				201.00
202.00		614,763	786,416	202.00
203.00		6,147.630000	0.009150	203.00
204.00		36,483	85,257	204.00
205.00		364.830000	0.000992	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151311

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

Worksheet C
Part I
Date/Time Prepared:
5/24/2014 10:35 am

		Title XVIII		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS		4,545,055	0	0	30.00	
31.00	03100 INTENSIVE CARE UNIT		1,433,787	0	0	31.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		3,710,887	0	0	50.00	
53.00	05300 ANESTHESIOLOGY		720,466	0	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		2,883,200	0	0	54.00	
60.00	06000 LABORATORY		2,244,097	0	0	60.00	
64.00	06400 INTRAVENOUS THERAPY		21,098	0	0	64.00	
65.00	06500 RESPIRATORY THERAPY	0	681,134	0	0	65.00	
66.00	06600 PHYSICAL THERAPY	0	1,769,199	0	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	567,858	0	0	67.00	
69.00	06900 ELECTROCARDIOLOGY		1,188,886	0	0	69.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		2,823,706	0	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		1,953,230	0	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		3,005,386	0	0	73.00	
73.02	07302 ONCOLOGY		522,265	0	0	73.02	
76.97	07697 CARDIAC REHABILITATION		182,456	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC		0	0	0	90.00	
91.00	09100 EMERGENCY		3,154,015	0	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	92.00	
92.01	09201 OBSERVATION BEDS (DISTINCT PART)		1,006,096	0	0	92.01	
OTHER REIMBURSABLE COST CENTERS							
98.00	05950 OTHER REIMBURSABLE COST CENTERS		0	0	0	98.00	
200.00	Subtotal (see instructions)	0	32,412,821	0	0	200.00	
201.00	Less Observation Beds	0	0	0	0	201.00	
202.00	Total (see instructions)	0	32,412,821	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151311

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

Worksheet C
Part I
Date/Time Prepared:
5/24/2014 10:35 am

		Title XVIII			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,667,660		2,667,660		30.00
31.00	03100	INTENSIVE CARE UNIT	541,130		541,130		31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,434,175	11,323,701	14,757,876	0.251451	50.00
53.00	05300	ANESTHESIOLOGY	1,004,108	1,993,379	2,997,487	0.240357	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	820,819	15,653,879	16,474,698	0.175008	54.00
60.00	06000	LABORATORY	1,328,045	7,649,217	8,977,262	0.249976	60.00
64.00	06400	INTRAVENOUS THERAPY	320,763	691,685	1,012,448	0.020839	64.00
65.00	06500	RESPIRATORY THERAPY	851,936	255,330	1,107,266	0.615149	65.00
66.00	06600	PHYSICAL THERAPY	640,760	2,183,254	2,824,014	0.626484	66.00
67.00	06700	OCCUPATIONAL THERAPY	302,016	644,678	946,694	0.599833	67.00
69.00	06900	ELECTROCARDIOLOGY	558,332	3,223,263	3,781,595	0.314387	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,908,460	1,676,634	4,585,094	0.615845	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,306,175	1,329,436	3,635,611	0.537249	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,081,616	5,035,193	8,116,809	0.370267	73.00
73.02	07302	ONCOLOGY	80,157	565,366	645,523	0.809057	73.02
76.97	07697	CARDIAC REHABILITATION	0	169,466	169,466	1.076653	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	161,866	4,955,340	5,117,206	0.616355	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	516,963	516,963	1.946166	92.01
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
200.00		Subtotal (see instructions)	21,008,018	57,866,784	78,874,802		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	21,008,018	57,866,784	78,874,802		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151311	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/24/2014 10:35 am
		Title XVIII	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
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
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	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
73.02	07302 ONCOLOGY	0.000000		73.02
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
OTHER REIMBURSABLE COST CENTERS				
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
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: 151311

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

Worksheet C
Part I
Date/Time Prepared:
5/24/2014 10:35 am

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		4,545,055	0	4,545,055	30.00
31.00	03100 INTENSIVE CARE UNIT		1,433,787	0	1,433,787	31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		3,710,887	0	3,710,887	50.00
53.00	05300 ANESTHESIOLOGY		720,466	0	720,466	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		2,883,200	0	2,883,200	54.00
60.00	06000 LABORATORY		2,244,097	0	2,244,097	60.00
64.00	06400 INTRAVENOUS THERAPY		21,098	0	21,098	64.00
65.00	06500 RESPIRATORY THERAPY	0	681,134	0	681,134	65.00
66.00	06600 PHYSICAL THERAPY	0	1,769,199	0	1,769,199	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	567,858	0	567,858	67.00
69.00	06900 ELECTROCARDIOLOGY		1,188,886	0	1,188,886	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		2,823,706	0	2,823,706	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		1,953,230	0	1,953,230	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		3,005,386	0	3,005,386	73.00
73.02	07302 ONCOLOGY		522,265	0	522,265	73.02
76.97	07697 CARDIAC REHABILITATION		182,456	0	182,456	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		0	0	0	90.00
91.00	09100 EMERGENCY		3,154,015	0	3,154,015	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)		1,006,096	0	1,006,096	92.01
OTHER REIMBURSABLE COST CENTERS						
98.00	05950 OTHER REIMBURSABLE COST CENTERS		0	0	0	98.00
200.00	Subtotal (see instructions)		32,412,821	0	32,412,821	200.00
201.00	Less Observation Beds		0	0	0	201.00
202.00	Total (see instructions)		32,412,821	0	32,412,821	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151311

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

Worksheet C
Part I
Date/Time Prepared:
5/24/2014 10:35 am

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,667,660		2,667,660		30.00
31.00	03100	INTENSIVE CARE UNIT	541,130		541,130		31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,434,175	11,323,701	14,757,876	0.251451	50.00
53.00	05300	ANESTHESIOLOGY	1,004,108	1,993,379	2,997,487	0.240357	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	820,819	15,653,879	16,474,698	0.175008	54.00
60.00	06000	LABORATORY	1,328,045	7,649,217	8,977,262	0.249976	60.00
64.00	06400	INTRAVENOUS THERAPY	320,763	691,685	1,012,448	0.020839	64.00
65.00	06500	RESPIRATORY THERAPY	851,936	255,330	1,107,266	0.615149	65.00
66.00	06600	PHYSICAL THERAPY	640,760	2,183,254	2,824,014	0.626484	66.00
67.00	06700	OCCUPATIONAL THERAPY	302,016	644,678	946,694	0.599833	67.00
69.00	06900	ELECTROCARDIOLOGY	558,332	3,223,263	3,781,595	0.314387	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,908,460	1,676,634	4,585,094	0.615845	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,306,175	1,329,436	3,635,611	0.537249	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,081,616	5,035,193	8,116,809	0.370267	73.00
73.02	07302	ONCOLOGY	80,157	565,366	645,523	0.809057	73.02
76.97	07697	CARDIAC REHABILITATION	0	169,466	169,466	1.076653	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	161,866	4,955,340	5,117,206	0.616355	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	516,963	516,963	1.946166	92.01
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
200.00		Subtotal (see instructions)	21,008,018	57,866,784	78,874,802		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	21,008,018	57,866,784	78,874,802		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151311	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/24/2014 10:35 am
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
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
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	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
73.02	07302 ONCOLOGY	0.000000		73.02
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
OTHER REIMBURSABLE COST CENTERS				
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151311	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/24/2014 10:35 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	548,903	14,757,876	0.037194	1,464,901	54,486	50.00
53.00	05300 ANESTHESIOLOGY	21,387	2,997,487	0.007135	405,223	2,891	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	294,822	16,474,698	0.017895	422,757	7,565	54.00
60.00	06000 LABORATORY	129,540	8,977,262	0.014430	649,801	9,377	60.00
64.00	06400 INTRAVENOUS THERAPY	1,695	1,012,448	0.001674	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	14,765	1,107,266	0.013335	172,856	2,305	65.00
66.00	06600 PHYSICAL THERAPY	243,301	2,824,014	0.086154	202,107	17,412	66.00
67.00	06700 OCCUPATIONAL THERAPY	14,969	946,694	0.015812	102,591	1,622	67.00
69.00	06900 ELECTROCARDIOLOGY	209,492	3,781,595	0.055398	456,327	25,280	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	77,011	4,585,094	0.016796	1,785,733	29,993	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	55,212	3,635,611	0.015186	471,389	7,159	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	59,547	8,116,809	0.007336	1,529,433	11,220	73.00
73.02	07302 ONCOLOGY	46,066	645,523	0.071362	9,504	678	73.02
76.97	07697 CARDIAC REHABILITATION	37,573	169,466	0.221714	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	290,093	5,117,206	0.056690	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	70,165	516,963	0.135725	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (lines 50-199)	2,114,541	75,666,012		7,672,622	169,988	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151311

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2014 10:35 am

Cost Center Description		Title XVIII				Hospital		Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost			
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
73.02	07302	ONCOLOGY	0	0	0	0	0	0	73.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS									
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	0	98.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151311	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/24/2014 10:35 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	14,757,876	0.000000	0.000000	1,464,901	50.00
53.00	05300 ANESTHESIOLOGY	0	2,997,487	0.000000	0.000000	405,223	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	16,474,698	0.000000	0.000000	422,757	54.00
60.00	06000 LABORATORY	0	8,977,262	0.000000	0.000000	649,801	60.00
64.00	06400 INTRAVENOUS THERAPY	0	1,012,448	0.000000	0.000000	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	1,107,266	0.000000	0.000000	172,856	65.00
66.00	06600 PHYSICAL THERAPY	0	2,824,014	0.000000	0.000000	202,107	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	946,694	0.000000	0.000000	102,591	67.00
69.00	06900 ELECTROCARDIOLOGY	0	3,781,595	0.000000	0.000000	456,327	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,585,094	0.000000	0.000000	1,785,733	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	3,635,611	0.000000	0.000000	471,389	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	8,116,809	0.000000	0.000000	1,529,433	73.00
73.02	07302 ONCOLOGY	0	645,523	0.000000	0.000000	9,504	73.02
76.97	07697 CARDIAC REHABILITATION	0	169,466	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	5,117,206	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	516,963	0.000000	0.000000	0	92.01
OTHER REIMBURSABLE COST CENTERS							
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00
200.00	Total (lines 50-199)	0	75,666,012			7,672,622	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151311

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2014 10:35 am

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)	Cost
		11.00	12.00	13.00	
Title XVIII Hospital					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
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
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
73.02	07302 ONCOLOGY	0	0	0	73.02
76.97	07697 CARDIAC REHABILITATION	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
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
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS					
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0	98.00
200.00	Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151311	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/24/2014 10:35 am
	Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.251451	0	3,348,103	0	0
53.00 05300 ANESTHESIOLOGY	0.240357	0	406,411	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.175008	0	5,336,061	0	0
60.00 06000 LABORATORY	0.249976	0	2,417,488	0	0
64.00 06400 INTRAVENOUS THERAPY	0.020839	0	647,735	0	0
65.00 06500 RESPIRATORY THERAPY	0.615149	0	31,006	0	0
66.00 06600 PHYSICAL THERAPY	0.626484	0	771,216	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.599833	0	235,008	0	0
69.00 06900 ELECTROCARDIOLOGY	0.314387	0	1,150,410	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.615845	0	831,770	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.537249	0	36,323	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.370267	0	3,188,265	4,623	0
73.02 07302 ONCOLOGY	0.809057	0	154,461	0	0
76.97 07697 CARDIAC REHABILITATION	1.076653	0	72,009	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0.000000	0	0	0	0
91.00 09100 EMERGENCY	0.616355	0	1,315,154	330	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	1.946166	0	204,233	0	0
OTHER REIMBURSABLE COST CENTERS					
98.00 05950 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0
200.00 Subtotal (see instructions)		0	20,145,653	4,953	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	20,145,653	4,953	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151311	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/24/2014 10:35 am
	Title XVIII	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	841,884	0		50.00
53.00 05300 ANESTHESIOLOGY	97,684	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	933,853	0		54.00
60.00 06000 LABORATORY	604,314	0		60.00
64.00 06400 INTRAVENOUS THERAPY	13,498	0		64.00
65.00 06500 RESPIRATORY THERAPY	19,073	0		65.00
66.00 06600 PHYSICAL THERAPY	483,154	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	140,966	0		67.00
69.00 06900 ELECTROCARDIOLOGY	361,674	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	512,241	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	19,514	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,180,509	1,712		73.00
73.02 07302 ONCOLOGY	124,968	0		73.02
76.97 07697 CARDIAC REHABILITATION	77,529	0		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	810,602	203		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	397,471	0		92.01
OTHER REIMBURSABLE COST CENTERS				
98.00 05950 OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00 Subtotal (see instructions)	6,618,934	1,915		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	6,618,934	1,915		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151311 Component CCN: 15Z311	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/24/2014 10:35 am
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.251451	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.240357	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.175008	0	0	0	0	54.00
60.00	06000	LABORATORY	0.249976	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.020839	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.615149	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.626484	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.599833	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.314387	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.615845	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.537249	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.370267	0	0	0	0	73.00
73.02	07302	ONCOLOGY	0.809057	0	0	0	0	73.02
76.97	07697	CARDIAC REHABILITATION	1.076653	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.616355	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1.946166	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		0	0	0	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	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151311 Component CCN: 15Z311	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/24/2014 10:35 am
	Title XVIII	Swing Beds - SNF	Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
73.02	07302	ONCOLOGY	0	0	73.02
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	92.01
OTHER REIMBURSABLE COST CENTERS					
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151311	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/24/2014 10:35 am
	Title XIX	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.251451	0	1,405,601	0	0
53.00 05300 ANESTHESIOLOGY	0.240357	0	398,464	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.175008	0	1,334,202	0	0
60.00 06000 LABORATORY	0.249976	0	485,532	0	0
64.00 06400 INTRAVENOUS THERAPY	0.020839	0	43,950	0	0
65.00 06500 RESPIRATORY THERAPY	0.615149	0	20,893	0	0
66.00 06600 PHYSICAL THERAPY	0.626484	0	94,628	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.599833	0	31,209	0	0
69.00 06900 ELECTROCARDIOLOGY	0.314387	0	262,222	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.615845	0	281,108	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.537249	0	0	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.370267	0	166,297	0	0
73.02 07302 ONCOLOGY	0.809057	0	6,371	0	0
76.97 07697 CARDIAC REHABILITATION	1.076653	0	4,826	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0.000000	0	0	0	0
91.00 09100 EMERGENCY	0.616355	0	740,586	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	1.946166	0	52,936	0	0
OTHER REIMBURSABLE COST CENTERS					
98.00 05950 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0
200.00 Subtotal (see instructions)		0	5,328,825	0	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	5,328,825	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151311	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/24/2014 10:35 am
		Title XIX	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	353,440	0	50.00
53.00	05300 ANESTHESIOLOGY	95,774	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	233,496	0	54.00
60.00	06000 LABORATORY	121,371	0	60.00
64.00	06400 INTRAVENOUS THERAPY	916	0	64.00
65.00	06500 RESPIRATORY THERAPY	12,852	0	65.00
66.00	06600 PHYSICAL THERAPY	59,283	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	18,720	0	67.00
69.00	06900 ELECTROCARDIOLOGY	82,439	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	173,119	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	61,574	0	73.00
73.02	07302 ONCOLOGY	5,155	0	73.02
76.97	07697 CARDIAC REHABILITATION	5,196	0	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	456,464	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	103,022	0	92.01
OTHER REIMBURSABLE COST CENTERS				
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	98.00
200.00	Subtotal (see instructions)	1,782,821	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	1,782,821	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151311	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XVIII		Hospital
				Date/Time Prepared: 5/24/2014 10:35 am
Cost Center Description				Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,538	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,674	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,674	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		1,590	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		274	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)		1,649	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)		1,590	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		129.14	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)		4,545,055	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)		35,384	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)		1,717,000	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,828,055	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,828,055	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,057.62	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,744,015	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)		1,744,015	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151311	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/24/2014 10:35 am		
Cost Center Description			Title XVIII		Hospital	Cost	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)					42.00	
Intensive Care Type Inpatient Hospital Units							
43.00	1,433,787	620	2,312.56	412	952,775	43.00	
44.00	CORONARY CARE UNIT					44.00	
45.00	BURN INTENSIVE CARE UNIT					45.00	
46.00	SURGICAL INTENSIVE CARE UNIT					46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00	
Cost Center Description							
					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,067,095	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,763,885	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					1,681,616	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)					1,681,616	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151311		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/24/2014 10:35 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151311	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/24/2014 10:35 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,077,240		30.00
31.00	03100 INTENSIVE CARE UNIT		371,900		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.251451	1,464,901	368,351	50.00
53.00	05300 ANESTHESIOLOGY	0.240357	405,223	97,398	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.175008	422,757	73,986	54.00
60.00	06000 LABORATORY	0.249976	649,801	162,435	60.00
64.00	06400 INTRAVENOUS THERAPY	0.020839	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.615149	172,856	106,332	65.00
66.00	06600 PHYSICAL THERAPY	0.626484	202,107	126,617	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.599833	102,591	61,537	67.00
69.00	06900 ELECTROCARDIOLOGY	0.314387	456,327	143,463	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.615845	1,785,733	1,099,735	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.537249	471,389	253,253	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.370267	1,529,433	566,299	73.00
73.02	07302 ONCOLOGY	0.809057	9,504	7,689	73.02
76.97	07697 CARDIAC REHABILITATION	1.076653	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.616355	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	1.946166	0	0	92.01
OTHER REIMBURSABLE COST CENTERS					
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50-94 and 96-98)		7,672,622	3,067,095	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)		7,672,622		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151311	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3	
		Component CCN: 15Z311		Date/Time Prepared: 5/24/2014 10:35 am	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.251451	301	50.00
53.00	05300	ANESTHESIOLOGY	0.240357	5,733	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.175008	124,915	54.00
60.00	06000	LABORATORY	0.249976	257,425	60.00
64.00	06400	INTRAVENOUS THERAPY	0.020839	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.615149	117,632	65.00
66.00	06600	PHYSICAL THERAPY	0.626484	211,833	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.599833	103,176	67.00
69.00	06900	ELECTROCARDIOLOGY	0.314387	94,561	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.615845	288,186	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.537249	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.370267	799,929	73.00
73.02	07302	ONCOLOGY	0.809057	5,952	73.02
76.97	07697	CARDIAC REHABILITATION	1.076653	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	0.616355	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1.946166	0	92.01
OTHER REIMBURSABLE COST CENTERS					
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	0	98.00
200.00		Total (sum of lines 50-94 and 96-98)		2,009,643	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)		2,009,643	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151311	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/24/2014 10:35 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		69,490		30.00
31.00	03100 INTENSIVE CARE UNIT		20,240		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.251451	112,663	28,329	50.00
53.00	05300 ANESTHESIOLOGY	0.240357	33,903	8,149	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.175008	19,282	3,375	54.00
60.00	06000 LABORATORY	0.249976	35,203	8,800	60.00
64.00	06400 INTRAVENOUS THERAPY	0.020839	22,596	471	64.00
65.00	06500 RESPIRATORY THERAPY	0.615149	25,530	15,705	65.00
66.00	06600 PHYSICAL THERAPY	0.626484	8,861	5,551	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.599833	3,794	2,276	67.00
69.00	06900 ELECTROCARDIOLOGY	0.314387	7,444	2,340	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.615845	107,438	66,165	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.537249	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.370267	85,255	31,567	73.00
73.02	07302 ONCOLOGY	0.809057	1,134	917	73.02
76.97	07697 CARDIAC REHABILITATION	1.076653	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.616355	26,079	16,074	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	1.946166	0	0	92.01
OTHER REIMBURSABLE COST CENTERS					
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50-94 and 96-98)		489,182	189,719	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)		489,182		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151311	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/24/2014 10:35 am
		Title XVII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			6,620,849 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			6,620,849 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 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)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			6,687,057 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)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			33,628 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			3,573,534 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)			3,079,895 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)			3,079,895 30.00
31.00	Primary payer payments			5,893 31.00
32.00	Subtotal (line 30 minus line 31)			3,074,002 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			564,259 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			496,548 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			359,934 36.00
37.00	Subtotal (see instructions)			3,570,550 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)			3,570,550 40.00
40.01	Sequestration adjustment (see instructions)			53,915 40.01
41.00	Interim payments			4,234,910 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			-718,275 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151311

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

Worksheet E-1
Part I
Date/Time Prepared:
5/24/2014 10:35 am

		Title XVIII		Hospital		Cost	
		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		4,174,549		4,234,910	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	07/08/2013	612,800		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)		612,800		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)		4,787,349		4,234,910	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		469,369		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		718,275	6.02	
7.00	Total Medicare program liability (see instructions)		5,256,718		3,516,635	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: 151311
Component CCN: 15Z311

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

Worksheet E-1
Part I
Date/Time Prepared:
5/24/2014 10:35 am

Title XVIII Swing Beds - SNF Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,133,810		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	07/08/2013	167,800		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)		167,800		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)		2,301,610		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		184,960		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,486,570		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: 151311	Period: From 01/01/2013 To 12/31/2013	Worksheet E-1 Part II Date/Time Prepared: 5/24/2014 10:35 am
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			955 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			2,061 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			231 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			3,294 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			78,874,802 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			0 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			78,123 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			69,983 8.00
9.00	Sequestration adjustment amount (see instructions)			1,400 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			68,583 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 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)			68,583 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151311

Period:

Worksheet E-2

Component CCN: 15Z311

From 01/01/2013

Date/Time Prepared:

To 12/31/2013

5/24/2014 10:35 am

		Title XVIII		Swing Beds - SNF	
		Part A	Part B		
		1.00	2.00		
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,698,432	0	1.00	
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00	
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 6 and 7, line 202 for Part B) (For CAH, see instructions)	871,462	0	3.00	
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00	
5.00	Program days	1,590	0	5.00	
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00	
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00	
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	2,569,894	0	8.00	
9.00	Primary payer payments (see instructions)	0	0	9.00	
10.00	Subtotal (line 8 minus line 9)	2,569,894	0	10.00	
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00	
12.00	Subtotal (line 10 minus line 11)	2,569,894	0	12.00	
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	45,201	0	13.00	
14.00	80% of Part B costs (line 12 x 80%)		0	14.00	
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	2,524,693	0	15.00	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00	
17.00	Allowable bad debts (see instructions)	0	0	17.00	
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01	
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00	
19.00	Total (see instructions)	2,524,693	0	19.00	
19.01	Sequestration adjustment (see instructions)	38,123	0	19.01	
20.00	Interim payments	2,301,610	0	20.00	
21.00	Tentative settlement (for contractor use only)	0	0	21.00	
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21	184,960	0	22.00	
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151311	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part V Date/Time Prepared: 5/24/2014 10:35 am
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services		5,763,885	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 thru 3)		5,763,885	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		5,821,524	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	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	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		5,821,524	19.00
20.00	Deductibles (exclude professional component)		521,502	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		5,300,022	22.00
23.00	Coinsurance		8,880	23.00
24.00	Subtotal (line 22 minus line 23)		5,291,142	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		52,465	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		46,169	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		11,021	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		5,337,311	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)		5,337,311	30.00
30.01	Sequestration adjustment (see instructions)		80,593	30.01
31.00	Interim payments		4,787,349	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program line 30 minus lines 30.01, 31, and 32		469,369	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	34.00

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

Provider CCN: 151311

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

Worksheet G

Date/Time Prepared:
5/24/2014 10:35 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	4,532,000	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	5,975,000	0	0	0	4.00
5.00	Other receivable	266,000	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,252,000	0	0	0	7.00
8.00	Prepaid expenses	140,000	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	12,165,000	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	1,505,000	0	0	0	17.00
18.00	Accumulated depreciation	-561,000	0	0	0	18.00
19.00	Fixed equipment	1,460,000	0	0	0	19.00
20.00	Accumulated depreciation	-924,000	0	0	0	20.00
21.00	Automobiles and trucks	6,000	0	0	0	21.00
22.00	Accumulated depreciation	-6,000	0	0	0	22.00
23.00	Major movable equipment	6,538,219	0	0	0	23.00
24.00	Accumulated depreciation	-4,485,627	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	806,781	0	0	0	27.00
28.00	Accumulated depreciation	-289,373	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)	4,050,000	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	5,089,000	0	0	0	31.00
32.00	Deposits on leases	11,840,000	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	8,464,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	25,393,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	41,608,000	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,240,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,518,000	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	889,000	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	1,731,000	0	0	0	43.00
44.00	Other current liabilities	1,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,379,000	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	18,905,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	581,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	19,486,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	25,865,000	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	15,743,000				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	15,743,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	41,608,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151311

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

Worksheet G-1

Date/Time Prepared:
5/24/2014 10:35 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		13,308,623		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		2,475,000				2.00
3.00	Total (sum of line 1 and line 2)		15,783,623		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		15,783,623		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	RECONCILING ITEM	40,623		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		40,623		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		15,743,000		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	RECONCILING ITEM		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: 151311

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/24/2014 10:35 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	13,232,000		13,232,000	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				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)	13,232,000		13,232,000	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	541,000		541,000	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	541,000		541,000	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	13,773,000		13,773,000	17.00
18.00	Ancillary services	8,674,000	67,816,000	76,490,000	18.00
19.00	Outpatient services	0	3,307,000	3,307,000	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		0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	22,447,000	71,123,000	93,570,000	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		40,313,020		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	ASSET IMPAIRMENT ADJUSTMENT	265,139			31.00
32.00	RECONCILING DIFFERENCE	4,841			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)		269,980		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)		40,583,000		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151311

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

Worksheet G-3

Date/Time Prepared:
5/24/2014 10:35 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	93,570,000	1.00
2.00	Less contractual allowances and discounts on patients' accounts	52,473,000	2.00
3.00	Net patient revenues (line 1 minus line 2)	41,097,000	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	40,583,000	4.00
5.00	Net income from service to patients (line 3 minus line 4)	514,000	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	295,864	6.00
7.00	Income from investments	398,000	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	54,851	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	109,054	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	189	16.00
17.00	Revenue from sale of drugs to other than patients	408,964	17.00
18.00	Revenue from sale of medical records and abstracts	9,242	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	18,787	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	2,446	21.00
22.00	Rental of hospital space	196,524	22.00
23.00	Governmental appropriations	116,685	23.00
24.00	OTHER REVENUE	350,394	24.00
25.00	Total other income (sum of lines 6-24)	1,961,000	25.00
26.00	Total (line 5 plus line 25)	2,475,000	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)	2,475,000	29.00