

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: 151312	Period: From 01/01/2013 To 12/31/2013	Worksheet S Parts I-III Date/Time Prepared: 6/30/2014 2: 24 pm
--	----------------------	---	---

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: 6/30/2014 Time: 2: 24 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH WHITE HOSPITAL (151312) 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	125,552	-745,945	-75,910	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	154,735	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
200.00 Total	0	280,287	-745,945	-75,910	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: 151312	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 6/30/2014 2:17 pm
---	--	----------------------	---	---

1.00 Hospital and Hospital Health Care Complex Address:	2.00 Street: 720 SOUTH SIXTH STREET	3.00 PO Box:	4.00 State: IN	5.00 Zip Code: 47960	6.00 County: WHITE	7.00	8.00	9.00	10.00
---	-------------------------------------	--------------	----------------	----------------------	--------------------	------	------	------	-------

1.00	Component Name	2.00	3.00	4.00	5.00	6.00 Payment System (P, T, O, or N)			7.00	8.00	9.00
						V	XVIII	XIX			
3.00 Hospital and Hospital-Based Component Identification:											
3.00	Hospital	IU HEALTH WHITE HOSPITAL	151312	99915	1	07/01/1966	N	O	O		3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF	IU HEALTH WHITE HOSPITAL	15Z312	99915		02/16/1990	N	O	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	HOME CARE OF WHITE COUNTY	157514	99915		03/01/1997	N	N	N		12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00

						From:		To:			
						1.00		2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2013		12/31/2013		20.00	
21.00	Type of Control (see instructions)							2		21.00	

22.00 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	

1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	10.00
24.00	0	0	0	0	0	0	0	0	24.00
25.00	0	0	0	0	0	0	0	0	25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151312	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 6/30/2014 2:17 pm		
		Urban/Rural S	Date of Geogr			
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	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		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151312		Period: From 01/01/2013 To 12/31/2013		Worksheet S-2 Part I Date/Time Prepared: 6/30/2014 2:17 pm	
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20	
					1.00		
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
<u>Teaching Hospitals that Claim Residents in Non-Provider Settings</u>							
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00	
				Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
<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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151312	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 6/30/2014 2:17 pm																																																																																																																																																																				
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))																																																																																																																																																																				
		1.00	2.00	3.00																																																																																																																																																																				
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010																																																																																																																																																																								
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00																																																																																																																																																																			
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))																																																																																																																																																																		
		1.00	2.00	3.00	4.00	5.00																																																																																																																																																																		
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000																																																																																																																																																																		
<table border="1"> <thead> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> <th>3.00</th> <th>4.00</th> <th>5.00</th> </tr> </thead> <tbody> <tr> <td colspan="7">Inpatient Psychiatric Facility PPS</td> </tr> <tr> <td>70.00</td> <td>Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.</td> <td></td> <td></td> <td></td> <td>N</td> <td></td> </tr> <tr> <td>71.00</td> <td>If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)</td> <td></td> <td></td> <td></td> <td></td> <td>0</td> </tr> <tr> <td colspan="7">Inpatient Rehabilitation Facility PPS</td> </tr> <tr> <td>75.00</td> <td>Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.</td> <td></td> <td></td> <td></td> <td>N</td> <td></td> </tr> <tr> <td>76.00</td> <td>If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)</td> <td></td> <td></td> <td></td> <td></td> <td>0</td> </tr> <tr> <td colspan="7"> <table border="1"> <thead> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> <th>3.00</th> <th>4.00</th> <th>5.00</th> </tr> </thead> <tbody> <tr> <td colspan="7">Long Term Care Hospital PPS</td> </tr> <tr> <td>80.00</td> <td>Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.</td> <td></td> <td></td> <td></td> <td>N</td> <td></td> </tr> <tr> <td colspan="7">TEFRA Providers</td> </tr> <tr> <td>85.00</td> <td>Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.</td> <td></td> <td></td> <td></td> <td>N</td> <td></td> </tr> <tr> <td>86.00</td> <td>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.</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="7"> <table border="1"> <thead> <tr> <th colspan="2"></th> <th>V</th> <th>XIX</th> </tr> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> </tr> </thead> <tbody> <tr> <td colspan="7">Title V and XIX Services</td> </tr> <tr> <td>90.00</td> <td>Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td>Y</td> <td>Y</td> <td></td> <td></td> </tr> <tr> <td>91.00</td> <td>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.</td> <td></td> <td>N</td> <td>N</td> <td></td> <td></td> </tr> <tr> <td>92.00</td> <td>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.</td> <td></td> <td></td> <td>N</td> <td></td> <td></td> </tr> <tr> <td>93.00</td> <td>Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>N</td> <td></td> <td></td> </tr> <tr> <td>94.00</td> <td>Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>N</td> <td></td> <td></td> </tr> <tr> <td>95.00</td> <td>If line 94 is "Y", enter the reduction percentage in the applicable column.</td> <td></td> <td>0.00</td> <td>0.00</td> <td></td> <td></td> </tr> </tbody> </table> </td> </tr> </tbody> </table> </td></tr></tbody></table>									1.00	2.00	3.00	4.00	5.00	Inpatient Psychiatric Facility PPS							70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N		71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	Inpatient Rehabilitation Facility PPS							75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N		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	<table border="1"> <thead> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> <th>3.00</th> <th>4.00</th> <th>5.00</th> </tr> </thead> <tbody> <tr> <td colspan="7">Long Term Care Hospital PPS</td> </tr> <tr> <td>80.00</td> <td>Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.</td> <td></td> <td></td> <td></td> <td>N</td> <td></td> </tr> <tr> <td colspan="7">TEFRA Providers</td> </tr> <tr> <td>85.00</td> <td>Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.</td> <td></td> <td></td> <td></td> <td>N</td> <td></td> </tr> <tr> <td>86.00</td> <td>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.</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="7"> <table border="1"> <thead> <tr> <th colspan="2"></th> <th>V</th> <th>XIX</th> </tr> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> </tr> </thead> <tbody> <tr> <td colspan="7">Title V and XIX Services</td> </tr> <tr> <td>90.00</td> <td>Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td>Y</td> <td>Y</td> <td></td> <td></td> </tr> <tr> <td>91.00</td> <td>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.</td> <td></td> <td>N</td> <td>N</td> <td></td> <td></td> </tr> <tr> <td>92.00</td> <td>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.</td> <td></td> <td></td> <td>N</td> <td></td> <td></td> </tr> <tr> <td>93.00</td> <td>Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>N</td> <td></td> <td></td> </tr> <tr> <td>94.00</td> <td>Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>N</td> <td></td> <td></td> </tr> <tr> <td>95.00</td> <td>If line 94 is "Y", enter the reduction percentage in the applicable column.</td> <td></td> <td>0.00</td> <td>0.00</td> <td></td> <td></td> </tr> </tbody> </table> </td> </tr> </tbody> </table>									1.00	2.00	3.00	4.00	5.00	Long Term Care Hospital PPS							80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N		TEFRA Providers							85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N		86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						<table border="1"> <thead> <tr> <th colspan="2"></th> <th>V</th> <th>XIX</th> </tr> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> </tr> </thead> <tbody> <tr> <td colspan="7">Title V and XIX Services</td> </tr> <tr> <td>90.00</td> <td>Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td>Y</td> <td>Y</td> <td></td> <td></td> </tr> <tr> <td>91.00</td> <td>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.</td> <td></td> <td>N</td> <td>N</td> <td></td> <td></td> </tr> <tr> <td>92.00</td> <td>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.</td> <td></td> <td></td> <td>N</td> <td></td> <td></td> </tr> <tr> <td>93.00</td> <td>Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>N</td> <td></td> <td></td> </tr> <tr> <td>94.00</td> <td>Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>N</td> <td></td> <td></td> </tr> <tr> <td>95.00</td> <td>If line 94 is "Y", enter the reduction percentage in the applicable column.</td> <td></td> <td>0.00</td> <td>0.00</td> <td></td> <td></td> </tr> </tbody> </table>									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.		Y	Y			91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N			92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N			93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N			94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N			95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00		
		1.00	2.00	3.00	4.00	5.00																																																																																																																																																																		
Inpatient Psychiatric Facility PPS																																																																																																																																																																								
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N																																																																																																																																																																			
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0																																																																																																																																																																		
Inpatient Rehabilitation Facility PPS																																																																																																																																																																								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N																																																																																																																																																																			
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																																																																																																																																																																		
<table border="1"> <thead> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> <th>3.00</th> <th>4.00</th> <th>5.00</th> </tr> </thead> <tbody> <tr> <td colspan="7">Long Term Care Hospital PPS</td> </tr> <tr> <td>80.00</td> <td>Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.</td> <td></td> <td></td> <td></td> <td>N</td> <td></td> </tr> <tr> <td colspan="7">TEFRA Providers</td> </tr> <tr> <td>85.00</td> <td>Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.</td> <td></td> <td></td> <td></td> <td>N</td> <td></td> </tr> <tr> <td>86.00</td> <td>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.</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="7"> <table border="1"> <thead> <tr> <th colspan="2"></th> <th>V</th> <th>XIX</th> </tr> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> </tr> </thead> <tbody> <tr> <td colspan="7">Title V and XIX Services</td> </tr> <tr> <td>90.00</td> <td>Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td>Y</td> <td>Y</td> <td></td> <td></td> </tr> <tr> <td>91.00</td> <td>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.</td> <td></td> <td>N</td> <td>N</td> <td></td> <td></td> </tr> <tr> <td>92.00</td> <td>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.</td> <td></td> <td></td> <td>N</td> <td></td> <td></td> </tr> <tr> <td>93.00</td> <td>Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>N</td> <td></td> <td></td> </tr> <tr> <td>94.00</td> <td>Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>N</td> <td></td> <td></td> </tr> <tr> <td>95.00</td> <td>If line 94 is "Y", enter the reduction percentage in the applicable column.</td> <td></td> <td>0.00</td> <td>0.00</td> <td></td> <td></td> </tr> </tbody> </table> </td> </tr> </tbody> </table>									1.00	2.00	3.00	4.00	5.00	Long Term Care Hospital PPS							80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N		TEFRA Providers							85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N		86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						<table border="1"> <thead> <tr> <th colspan="2"></th> <th>V</th> <th>XIX</th> </tr> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> </tr> </thead> <tbody> <tr> <td colspan="7">Title V and XIX Services</td> </tr> <tr> <td>90.00</td> <td>Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td>Y</td> <td>Y</td> <td></td> <td></td> </tr> <tr> <td>91.00</td> <td>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.</td> <td></td> <td>N</td> <td>N</td> <td></td> <td></td> </tr> <tr> <td>92.00</td> <td>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.</td> <td></td> <td></td> <td>N</td> <td></td> <td></td> </tr> <tr> <td>93.00</td> <td>Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>N</td> <td></td> <td></td> </tr> <tr> <td>94.00</td> <td>Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>N</td> <td></td> <td></td> </tr> <tr> <td>95.00</td> <td>If line 94 is "Y", enter the reduction percentage in the applicable column.</td> <td></td> <td>0.00</td> <td>0.00</td> <td></td> <td></td> </tr> </tbody> </table>									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.		Y	Y			91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N			92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N			93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N			94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N			95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00																																																										
		1.00	2.00	3.00	4.00	5.00																																																																																																																																																																		
Long Term Care Hospital PPS																																																																																																																																																																								
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N																																																																																																																																																																			
TEFRA Providers																																																																																																																																																																								
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N																																																																																																																																																																			
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.																																																																																																																																																																							
<table border="1"> <thead> <tr> <th colspan="2"></th> <th>V</th> <th>XIX</th> </tr> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> </tr> </thead> <tbody> <tr> <td colspan="7">Title V and XIX Services</td> </tr> <tr> <td>90.00</td> <td>Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td>Y</td> <td>Y</td> <td></td> <td></td> </tr> <tr> <td>91.00</td> <td>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.</td> <td></td> <td>N</td> <td>N</td> <td></td> <td></td> </tr> <tr> <td>92.00</td> <td>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.</td> <td></td> <td></td> <td>N</td> <td></td> <td></td> </tr> <tr> <td>93.00</td> <td>Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>N</td> <td></td> <td></td> </tr> <tr> <td>94.00</td> <td>Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>N</td> <td></td> <td></td> </tr> <tr> <td>95.00</td> <td>If line 94 is "Y", enter the reduction percentage in the applicable column.</td> <td></td> <td>0.00</td> <td>0.00</td> <td></td> <td></td> </tr> </tbody> </table>									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.		Y	Y			91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N			92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N			93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N			94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N			95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00																																																																																																											
		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.		Y	Y																																																																																																																																																																				
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N																																																																																																																																																																				
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N																																																																																																																																																																				
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N																																																																																																																																																																				
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N																																																																																																																																																																				
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00																																																																																																																																																																				

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151312	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 6/30/2014 2:17 pm		
		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.	Y	Y	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:	38,259	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151312	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 6/30/2014 2:17 pm		
		1.00	2.00			
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	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: 340 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.	Y			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)	15,000			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	
				Beginning	Ending	
				1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2012		09/30/2013		170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151312	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 6/30/2014 2:17 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	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	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	05/13/2014	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 151312

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

Worksheet S-2
Part II
Date/Time Prepared:
6/30/2014 2:17 pm

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			Y	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	
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH			
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.962.1093		RUTTER@IUHEALTH.ORG	

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	05/13/2014	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER, 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: 151312

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

Worksheet S-3
Part I
Date/Time Prepared:
6/30/2014 2:17 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	24	8,760	57,720.00	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)		24	8,760	57,720.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	1	365	2,280.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,125	60,000.00	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	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)	115.00					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: 151312

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

Worksheet S-3
Part I
Date/Time Prepared:
6/30/2014 2:17 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,454	334	2,405			1.00
2.00 HMO and other (see instructions)	248	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	885	0	885			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	91			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	2,339	334	3,381			7.00
8.00 INTENSIVE CARE UNIT	57	5	95			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		268	395			13.00
14.00 Total (see instructions)	2,396	607	3,871	0.00	195.80	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	0	0	0	0.00	0.00	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				0.00	0.00	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	195.80	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: 151312

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

Worksheet S-3
Part I
Date/Time Prepared:
6/30/2014 2:17 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	442	243	959	1.00
2.00 HMO and other (see instructions)			0			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	442	243	959	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	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)	0.00					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: 151312	Period: From 01/01/2013 To 12/31/2013	Worksheet S-10 Date/Time Prepared: 6/30/2014 2:17 pm
---	----------------------	---	--

			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)		0.458253	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		3,926,000	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		6,988,000	6.00
7.00	Medicaid cost (line 1 times line 6)		3,202,272	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone SCHIP		0	9.00
10.00	Stand-alone SCHIP charges		0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Uncompensated care (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00
			1.00	
			2.00	
			3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	3,588,954	0	3,588,954
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,644,649	0	1,644,649
22.00	Partial payment by patients approved for charity care	64,201	0	64,201
23.00	Cost of charity care (line 21 minus line 22)	1,580,448	0	1,580,448
			1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		4,630,000	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		531,252	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		4,098,748	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,878,264	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		3,458,712	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,458,712	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151312

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

Worksheet A
Date/Time Prepared:
6/30/2014 2:17 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		21,729	21,729	0	21,729	1.00
1.01	00101		2,722,079	2,722,079	0	2,722,079	1.01
1.02	00102		390,844	390,844	0	390,844	1.02
4.00	00400	76,730	2,125,285	2,202,015	-5,670	2,196,345	4.00
5.00	00500	1,355,939	2,521,817	3,877,756	-2	3,877,754	5.00
7.00	00700	154,819	5,431	160,250	0	160,250	7.00
7.01	00701	0	659,075	659,075	0	659,075	7.01
7.02	00702	0	252,377	252,377	0	252,377	7.02
8.00	00800	0	73,804	73,804	0	73,804	8.00
9.00	00900	282,854	90,149	373,003	0	373,003	9.00
10.00	01000	468,770	253,895	722,665	-145,026	577,639	10.00
11.00	01100	0	0	0	145,026	145,026	11.00
13.00	01300	565,435	42,499	607,934	0	607,934	13.00
14.00	01400	75,865	71,457	147,322	-195	147,127	14.00
15.00	01500	365,015	2,140,057	2,505,072	148,141	2,653,213	15.00
16.00	01600	196,867	20,604	217,471	0	217,471	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,164,117	479,230	1,643,347	-66,572	1,576,775	30.00
31.00	03100	89,032	33,859	122,891	-5,129	117,762	31.00
43.00	04300	140,731	10,575	151,306	-43,451	107,855	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	733,732	997,393	1,731,125	-18,606	1,712,519	50.00
52.00	05200	0	0	0	98,915	98,915	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	362,738	375,623	738,361	-5,805	732,556	54.00
55.00	05500	56,884	142,489	199,373	-30,829	168,544	55.00
56.00	05600	153,996	184,416	338,412	-15	338,397	56.00
57.00	05700	142,681	326,062	468,743	-31,704	437,039	57.00
58.00	05800	96,434	362,101	458,535	-5,224	453,311	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	627,387	765,398	1,392,785	-253	1,392,532	60.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	350,429	38,413	388,842	-495	388,347	66.00
67.00	06700	81,639	2,020	83,659	100	83,759	67.00
68.00	06800	67,600	1,347	68,947	0	68,947	68.00
69.00	06900	30,104	45,510	75,614	0	75,614	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	8,645	8,645	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	159,095	138,997	298,092	-5,276	292,816	75.01
75.02	07502	366,081	55,067	421,148	249	421,397	75.02
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	79,747	20,466	100,213	-313	99,900	90.00
91.00	09100	908,283	942,760	1,851,043	-36,086	1,814,957	91.00
92.00	09200						92.00
92.01	09201	90,478	3,277	93,755	-425	93,330	92.01
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	0	0	0	0	0	98.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		0	0	0	0	113.00
114.00	11400	0	0	0	0	0	114.00
115.00	11500	0	0	0	0	0	115.00
118.00		9,243,482	16,316,105	25,559,587	0	25,559,587	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	6,024	6,024	0	6,024	192.02
192.04	19204	327	745	1,072	0	1,072	192.04
192.05	19205	0	0	0	0	0	192.05
193.00	19300	0	0	0	0	0	193.00
200.00		9,243,809	16,322,874	25,566,683	0	25,566,683	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151312

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

Worksheet A
Date/Time Prepared:
6/30/2014 2:17 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	162,517	184,246	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	112,229	2,834,308	1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB	142,377	533,221	1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	183,943	2,380,288	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,758,893	6,636,647	5.00
7.00	00700	OPERATION OF PLANT	145,102	305,352	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	659,075	7.01
7.02	00702	OPERATION OF PLANT - TUMOB	0	252,377	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	73,804	8.00
9.00	00900	HOUSEKEEPING	21,668	394,671	9.00
10.00	01000	DIETARY	-221,661	355,978	10.00
11.00	01100	CAFETERIA	-69,302	75,724	11.00
13.00	01300	NURSING ADMINISTRATION	0	607,934	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-10,419	136,708	14.00
15.00	01500	PHARMACY	-30,816	2,622,397	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-343	217,128	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-276,720	1,300,055	30.00
31.00	03100	INTENSIVE CARE UNIT	0	117,762	31.00
43.00	04300	NURSERY	0	107,855	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-576,282	1,136,237	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	98,915	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	732,556	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	168,544	55.00
56.00	05600	RADIOISOTOPE	0	338,397	56.00
57.00	05700	CT SCAN	-70,446	366,593	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	453,311	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	1,392,532	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	-3,570	384,777	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	83,759	67.00
68.00	06800	SPEECH PATHOLOGY	0	68,947	68.00
69.00	06900	ELECTROCARDIOLOGY	0	75,614	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,645	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
75.01	07501	ONCOLOGY	-111,000	181,816	75.01
75.02	07502	CARDIOPULMONARY	0	421,397	75.02
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	99,900	90.00
91.00	09100	EMERGENCY	-3,425	1,811,532	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	93,330	92.01
OTHER REIMBURSABLE COST CENTERS					
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,152,745	27,712,332	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	ARNETT SURGERY OFFICE	0	0	192.01
192.02	19202	TLMOB	0	6,024	192.02
192.04	19204	OCCUPATIONAL MEDICINE	0	1,072	192.04
192.05	19205	VENDING ROOM	0	0	192.05
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		TOTAL (SUM OF LINES 118-199)	2,152,745	27,719,428	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	94,398	50,628	1.00
	TOTALS		94,398	50,628	
B - OB NURSERY LDR SERVICES					
1.00	NURSERY	43.00	0	7,706	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	82,664	16,766	2.00
	TOTALS		82,664	24,472	
C - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	8,645	1.00
	TOTALS		0	8,645	
D - OCCUPATIONAL THERAPY SERVICES					
1.00	OCCUPATIONAL THERAPY	67.00	0	225	1.00
	TOTALS		0	225	
E - PHARMACY SERVICES					
1.00	PHARMACY	15.00	0	148,141	1.00
2.00	CARDIOPULMONARY	75.02	0	249	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
	TOTALS		0	148,390	
500.00	Grand Total: Increases		177,062	232,360	500.00

RECLASSIFICATIONS

Provider CCN: 151312

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

Worksheet A-6

Date/Time Prepared:
6/30/2014 2:17 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	94,398	50,628	0		1.00
	TOTALS		94,398	50,628			
	B - OB NURSERY LDR SERVICES						
1.00	ADULTS & PEDIATRICS	30.00	32,068	24,472	0		1.00
2.00	NURSERY	43.00	50,596	0	0		2.00
	TOTALS		82,664	24,472			
	C - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0	8,645	0		1.00
	TOTALS		0	8,645			
	D - OCCUPATIONAL THERAPY SERVICES						
1.00	PHYSICAL THERAPY	66.00	0	225	0		1.00
	TOTALS		0	225			
	E - PHARMACY SERVICES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5,670	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	2	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	195	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	10,032	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	5,129	0		5.00
6.00	NURSERY	43.00	0	561	0		6.00
7.00	OPERATING ROOM	50.00	0	9,961	0		7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	515	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,805	0		9.00
10.00	RADIOLOGY-THERAPEUTIC	55.00	0	30,829	0		10.00
11.00	RADIOISOTOPE	56.00	0	15	0		11.00
12.00	CT SCAN	57.00	0	31,704	0		12.00
13.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	5,224	0		13.00
14.00	LABORATORY	60.00	0	253	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	270	0		15.00
16.00	OCCUPATIONAL THERAPY	67.00	0	125	0		16.00
17.00	ONCOLOGY	75.01	0	5,276	0		17.00
18.00	CLINIC	90.00	0	313	0		18.00
19.00	EMERGENCY	91.00	0	36,086	0		19.00
20.00	OBSERVATION BEDS (DISTINCT PART)	92.01	0	425	0		20.00
	TOTALS		0	148,390			
500.00	Grand Total: Decreases		177,062	232,360			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151312

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

Worksheet A-7
Part I
Date/Time Prepared:
6/30/2014 2:17 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	954,570	0	0	0	1.00
2.00	Land Improvements	1,982,123	0	0	0	2.00
3.00	Buildings and Fixtures	31,975,073	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	7,258,988	1,553,769	0	1,553,769	6.00
7.00	HIT designated Assets	315,139	15,000	0	15,000	7.00
8.00	Subtotal (sum of lines 1-7)	42,485,893	1,568,769	0	1,568,769	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	42,485,893	1,568,769	0	1,568,769	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	954,570	0			1.00
2.00	Land Improvements	1,982,123	0			2.00
3.00	Buildings and Fixtures	31,975,073	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	8,812,757	0			6.00
7.00	HIT designated Assets	330,139	0			7.00
8.00	Subtotal (sum of lines 1-7)	44,054,662	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	44,054,662	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151312

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

Worksheet A-7
Part II
Date/Time Prepared:
6/30/2014 2:17 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	21,729	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1,378,954	0	1,216,102	125,262	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	254,200	0	136,644	0	0	1.02
3.00	Total (sum of lines 1-2)	1,654,883	0	1,352,746	125,262	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	21,729		1.00		
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1,761	2,722,079		1.01		
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	390,844		1.02		
3.00	Total (sum of lines 1-2)	1,761	3,134,652		3.00		

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151312

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

Worksheet A-7
Part III
Date/Time Prepared:
6/30/2014 2:17 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	1,982,123	0	1,982,123	0.045989	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	32,561,197	0	32,561,197	0.755478	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	8,556,773	0	8,556,773	0.198533	0	1.02
3.00	Total (sum of lines 1-2)	43,100,093	0	43,100,093	0.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	184,246	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	0	1,549,020	-42,064	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	0	397,725	0	1.02
3.00	Total (sum of lines 1-2)	0	0	0	2,130,991	-42,064	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	184,246	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1,200,329	125,262	0	1,761	2,834,308	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	135,496	0	0	0	533,221	1.02
3.00	Total (sum of lines 1-2)	1,335,825	125,262	0	1,761	3,551,775	3.00

Line #	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 #			
				3.00	4.00			
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 - HOSPITAL (chapter 2)			0	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	1.01
1.02	Investment income - CAP REL COSTS-BLDG & FIXT - TLMOB (chapter 2)			0	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-3,423		ADMINISTRATIVE & GENERAL	5.00	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)	A	-7,347		ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)			0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-824,974				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	3,404,076				0	12.00
13.00	Laundry and linen service			0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-72,335		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	-343		MEDICAL RECORDS & LIBRARY	16.00	0	16.00
17.00	Sale of drugs to other than patients	B	-30,816		PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts			0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00	Vending machines			0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3			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)				UTILIZATION REVIEW-SNF	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	162,517		CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT - HOSPITAL	A	57,840		CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9	26.01
26.02	Depreciation - CAP REL COSTS-BLDG & FIXT - TLMOB	A	143,525		CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	9	26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151312

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

Worksheet A-8

Date/Time Prepared:
6/30/2014 2:17 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center	Line #		
			1.00	2.00	3.00	
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00	30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00	30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-96,757		CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9 32.00
33.00 DR. APPLICATION FEE - OTHER REV	B	-5,325		ADMINISTRATIVE & GENERAL	5.00	0 33.00
33.01 PHYSICIAN RECRUITMENT	A	-10,000		ADMINISTRATIVE & GENERAL	5.00	0 33.01
33.02 MISCELLANEOUS REVENUE	B	-1,841		ADMINISTRATIVE & GENERAL	5.00	0 33.02
33.03 MISCELLANEOUS REVENUE	B	-22,908		DIETARY	10.00	0 33.03
33.04 ADVERTISING	A	-274		ADMINISTRATIVE & GENERAL	5.00	0 33.04
33.05 IHHA & AHA LOBBYING	A	-2,590		ADMINISTRATIVE & GENERAL	5.00	0 33.05
33.06 CRNA EXPENSE	A	-199,459		OPERATING ROOM	50.00	0 33.06
33.07 INTEREST INCOME	B	-10,220		CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	11 33.07
33.08 INTEREST INCOME	B	-1,148		CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	11 33.08
33.09 SAFE SITTER	B	-750		ADMINISTRATIVE & GENERAL	5.00	0 33.09
33.10 MARKETING	A	-120,000		ADMINISTRATIVE & GENERAL	5.00	0 33.10
33.11 CPR	B	-3,452		ADMINISTRATIVE & GENERAL	5.00	0 33.11
33.12 CASH SHORT OR LONG	B	47		ADMINISTRATIVE & GENERAL	5.00	0 33.12
33.13 WIC PROGRAM	A	-198,314		DIETARY	10.00	0 33.13
33.14 WIC PROGRAM BENEFITS	A	-27,339		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.14
33.15 DIETARY MISC REVENUE	B	-439		DIETARY	10.00	0 33.15
33.16 MATERIALS MANAGEMENT	B	-10,980		CENTRAL SERVICES & SUPPLY	14.00	0 33.16
33.17 COPIES	B	-100		ADMINISTRATIVE & GENERAL	5.00	0 33.17
33.18 MAGNETATION PT EVALS	B	-3,570		PHYSICAL THERAPY	66.00	0 33.18
33.19 ENPC EMERG NURSE	B	-3,425		EMERGENCY	91.00	0 33.19
33.20 LOSS ON ABANDONMENT	A	97,528		CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9 33.20
33.21 LOSS ON ABANDONED ASSETS	A	2,875		CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9 33.21
33.22 HAF CONTRIBUTION	A	-1,288		ADMINISTRATIVE & GENERAL	5.00	0 33.22
33.23 DEPRECIATION ON EHR ASSETS - 2013	A	-4,167		CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9 33.23
33.24		0			0.00	0 33.24
33.25 OPERATING ROOM LEASES	A	-7,723		OPERATING ROOM	50.00	0 33.25
33.26 ROUTINE LEASES	A	-2,292		ADULTS & PEDIATRICS	30.00	0 33.26
33.27 CAPITAL LEASE - ROUTINE	A	-14,581		CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	10 33.27
33.28 CAPITAL LEASE - DIETARY	A	-27,483		CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	10 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
33.49 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.)		2,152,745				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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

Provider CCN: 151312

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

Worksheet A-8-1

Date/Time Prepared: 6/30/2014 2:17 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.01	CAP REL COSTS-BLDG & FIXT - HOME OFFICE - BLDG DEPRECIAT	76,203	0	1.00
2.00	1.01	CAP REL COSTS-BLDG & FIXT - HOME OFFICE - INTEREST EXPEN	1,168,241	1,173,794	2.00
3.00	1.01	CAP REL COSTS-BLDG & FIXT - HOME OFFICE - EQUIPMENT DEPR	36,544	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT HOME OFFICE - EMPLOYEE BENEF	213,297	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL HOME OFFICE - REV CYCLE	30,990	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL HOME OFFICE - DATA PROCESSIN	128,913	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL HOME OFFICE - OTHER ADMIN &	625,235	0	4.03
4.04	7.00	OPERATION OF PLANT HOME OFFICE - MAINT & REPAIR	3,488	0	4.04
4.05	7.00	OPERATION OF PLANT HOME OFFICE - OPERATION OF P	141,614	0	4.05
4.06	9.00	HOUSEKEEPING HOME OFFICE - HOUSEKEEPING	21,668	0	4.06
4.07	11.00	CAFETERIA HOME OFFICE - CAFETERIA	3,033	0	4.07
4.08	14.00	CENTRAL SERVICES & SUPPLY HOME OFFICE - PURCHASING	561	0	4.08
4.09	57.00	CT SCAN RADIOLOGY - CT SCANS (SLA)	70,446	70,446	4.09
4.10	30.00	ADULTS & PEDIATRICS OB SHARED EMPLOYEES (SLA)	3,280	3,280	4.10
4.11	50.00	OPERATING ROOM SURGERY ON-CALL (SLA)	57,500	57,500	4.11
4.12	13.00	NURSING ADMINISTRATION RESOURCE POOL (SLA)	22,965	22,965	4.12
4.13	4.00	EMPLOYEE BENEFITS DEPARTMENT ARNETT - EMPLOYEE BENEFITS	23,192	25,207	4.13
4.14	4.00	EMPLOYEE BENEFITS DEPARTMENT ARNETT - HUMAN RESOURCES (S	98,517	98,517	4.14
4.15	5.00	ADMINISTRATIVE & GENERAL ARNETT - ADMINISTRATIVE & GE	2,130,098	0	4.15
4.16	5.00	ADMINISTRATIVE & GENERAL ARNETT - ADMIN & GENERAL (SL	512,294	512,294	4.16
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.		5,368,079	1,964,003	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.

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	0.00	6.00
7.00	C	IUH ARNETT	1.00	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: 151312

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

Worksheet A-8-1

Date/Time Prepared:
6/30/2014 2:17 pm

	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	76,203	9	1.00
2.00	-5,553	11	2.00
3.00	36,544	9	3.00
4.00	213,297	0	4.00
4.01	30,990	0	4.01
4.02	128,913	0	4.02
4.03	625,235	0	4.03
4.04	3,488	0	4.04
4.05	141,614	0	4.05
4.06	21,668	0	4.06
4.07	3,033	0	4.07
4.08	561	0	4.08
4.09	0	0	4.09
4.10	0	0	4.10
4.11	0	0	4.11
4.12	0	0	4.12
4.13	-2,015	0	4.13
4.14	0	0	4.14
4.15	2,130,098	0	4.15
4.16	0	0	4.16
5.00	3,404,076		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		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: 151312

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

Worksheet A-8-2

Date/Time Prepared:
6/30/2014 2:17 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	274,428	274,428	0	0	0	1.00
2.00	50.00	OPERATING ROOM	88,500	88,500	0	0	0	2.00
3.00	50.00	OPERATING ROOM	280,600	280,600	0	0	0	3.00
4.00	50.00	OPERATING ROOM	57,500	0	57,500	0	0	4.00
5.00	57.00	CT SCAN	70,446	70,446	0	0	0	5.00
6.00	60.00	LABORATORY	38,235	0	38,235	0	0	6.00
7.00	75.01	ONCOLOGY	111,000	111,000	0	0	0	7.00
8.00	91.00	EMERGENCY	738,000	0	738,000	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			1,658,709	824,974	833,735			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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	57.00	CT SCAN	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	75.01	ONCOLOGY	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	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	30.00	ADULTS & PEDIATRICS	0	0	0	274,428	1.00
2.00	50.00	OPERATING ROOM	0	0	0	88,500	2.00
3.00	50.00	OPERATING ROOM	0	0	0	280,600	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	4.00
5.00	57.00	CT SCAN	0	0	0	70,446	5.00
6.00	60.00	LABORATORY	0	0	0	0	6.00
7.00	75.01	ONCOLOGY	0	0	0	111,000	7.00
8.00	91.00	EMERGENCY	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	824,974	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151312		Period: From 01/01/2013 To 12/31/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 6/30/2014 2:17 pm	
		Physical Therapy		Cost			
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					9	1.00
2.00	Line 1 multiplied by 15 hours per week					135	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					16	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					4.85	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	0.00	54.50	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	64.41	48.31	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	32.21	32.21	24.16			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					0	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					2,633	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					2,633	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					2,633	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					48.31	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					6,522	22.00
23.00	Total salary equivalency (see instructions)					6,522	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					387	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					387	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					78	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					465	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					465	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					78	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151312				Period: From 01/01/2013 To 12/31/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 6/30/2014 2:17 pm	
						Physical Therapy		Cost	
								1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)							0	46.00
		Therapists	Assistants	Aides	Trainees	Total			
		1.00	2.00	3.00	4.00	5.00			
PART V - OVERTIME COMPUTATION									
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		0	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		0	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00		0	49.00
CALCULATION OF LIMIT									
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		0	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00		0	51.00
DETERMINATION OF OVERTIME ALLOWANCE									
52.00	Adjusted hourly salary equivalency amount (see instructions)	64.41	48.31	0.00	0.00			0	52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0			0	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0			0	54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0			0	55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0			0	56.00
								1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT									
57.00	Salary equivalency amount (from line 23)							6,522	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))							465	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)							0	59.00
60.00	Overtime allowance (from column 5, line 56)							0	60.00
61.00	Equipment cost (see instructions)							0	61.00
62.00	Supplies (see instructions)							0	62.00
63.00	Total allowance (sum of lines 57-62)							6,987	63.00
64.00	Total cost of outside supplier services (from your records)							2,841	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)							0	65.00
LINE 33 CALCULATION									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others							387	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							78	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27							465	100.02
LINE 34 CALCULATION									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							78	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							0	101.01
101.02	Line 34 = sum of lines 27 and 31							78	101.02
LINE 35 CALCULATION									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others							0	102.01
102.02	Line 35 = sum of lines 31 and 32							0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151312		Period: From 01/01/2013 To 12/31/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 6/30/2014 2:17 pm	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					1	1.00
2.00	Line 1 multiplied by 15 hours per week					15	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					2	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					4.85	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	0.00	5.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	0.00	48.31	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	0.00	0.00	24.16			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					0	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					242	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					242	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					242	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					48.40	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					726	22.00
23.00	Total salary equivalency (see instructions)					726	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					10	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					10	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					10	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					10	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151312		Period: From 01/01/2013 To 12/31/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 6/30/2014 2:17 pm	
				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	0.00	48.31	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					726	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					10	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					736	63.00
64.00	Total cost of outside supplier services (from your records)					287	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					10	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					10	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					10	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					10	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151312

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

Worksheet B
Part I
Date/Time Prepared:
6/30/2014 2:17 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	BLDG & FIXT - HOSPITAL	BLDG & FIXT - TLMOB		
	0	1.00	1.01	1.02	4.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	184,246	184,246			1.00
1.01 00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	2,834,308	0	2,834,308		1.01
1.02 00102	CAP REL COSTS-BLDG & FIXT - TLMOB	533,221	0	0	533,221	1.02
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,380,288	0	0		2,380,288
5.00 00500	ADMINISTRATIVE & GENERAL	6,636,647	22,550	182,828	124,135	357,046
7.00 00700	OPERATION OF PLANT	305,352	0	0	0	40,766
7.01 00701	OPERATION OF PLANT - HOSPITAL	659,075	8,730	139,303	23,470	0
7.02 00702	OPERATION OF PLANT - TUMOB	252,377	1,632	0	13,732	0
8.00 00800	LAUNDRY & LINEN SERVICE	73,804	0	0	0	0
9.00 00900	HOUSEKEEPING	394,671	4,311	96,807	1,532	74,480
10.00 01000	DIETARY	355,978	3,878	0	32,634	65,014
11.00 01100	CAFETERIA	75,724	3,797	0	31,950	24,857
13.00 01300	NURSING ADMINISTRATION	607,934	280	0	2,352	148,889
14.00 01400	CENTRAL SERVICES & SUPPLY	136,708	2,282	53,511	0	19,977
15.00 01500	PHARMACY	2,622,397	2,832	66,393	0	96,115
16.00 01600	MEDICAL RECORDS & LIBRARY	217,128	2,562	0	21,555	51,838
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,300,055	27,355	641,439	0	298,088
31.00 03100	INTENSIVE CARE UNIT	117,762	3,277	76,836	0	23,444
43.00 04300	NURSERY	107,855	660	15,474	0	23,734
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,136,237	17,590	412,458	0	193,204
52.00 05200	DELIVERY ROOM & LABOR ROOM	98,915	1,255	29,423	0	21,767
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	732,556	11,126	260,883	0	95,515
55.00 05500	RADIOLOGY-THERAPEUTIC	168,544	668	15,664	0	14,979
56.00 05600	RADIOISOTOPE	338,397	587	13,759	0	40,550
57.00 05700	CT SCAN	366,593	803	18,828	0	37,570
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	453,311	0	0	0	25,393
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 06000	LABORATORY	1,392,532	4,595	107,745	0	165,202
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	0
66.00 06600	PHYSICAL THERAPY	384,777	4,202	98,522	0	92,274
67.00 06700	OCCUPATIONAL THERAPY	83,759	0	0	0	21,497
68.00 06800	SPEECH PATHOLOGY	68,947	0	0	0	17,800
69.00 06900	ELECTROCARDIOLOGY	75,614	686	16,084	0	7,927
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	8,645	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00 07400	RENAL DIALYSIS	0	0	0	0	0
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
75.01 07501	ONCOLOGY	181,816	3,044	71,386	0	41,892
75.02 07502	CARDIOPULMONARY	421,397	2,584	60,600	0	96,395
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	99,900	0	0	0	20,999
91.00 09100	EMERGENCY	1,811,532	13,176	308,944	0	239,166
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
92.01 09201	OBSERVATION BEDS (DISTINCT PART)	93,330	6,287	147,421	0	23,824
OTHER REIMBURSABLE COST CENTERS						
98.00 05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
114.00 11400	UTILIZATION REVIEW-SNF					
115.00 11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	27,712,332	150,749	2,834,308	251,360	2,380,202
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00 19100	RESEARCH	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	6,450	0	54,271	0
192.01 19201	ARNETT SURGERY OFFICE	0	2,854	0	24,017	0
192.02 19202	TLMOB	6,024	24,112	0	202,889	0
192.04 19204	OCCUPATIONAL MEDICINE	1,072	0	0	0	86
192.05 19205	VENDING ROOM	0	81	0	684	0
193.00 19300	NONPAID WORKERS	0	0	0	0	0
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151312

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

Worksheet B
Part I
Date/Time Prepared:
6/30/2014 2:17 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	BLDG & FIXT - HOSPITAL	BLDG & FIXT - TLMOB		
	0	1.00	1.01	1.02	4.00	
202.00 TOTAL (sum lines 118-201)	27,719,428	184,246	2,834,308	533,221	2,380,288	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151312

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

Worksheet B
Part I
Date/Time Prepared:
6/30/2014 2:17 pm

Cost Center Description		Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - HOSPITAL	OPERATION OF PLANT - TUMOB	
		4A	5.00	7.00	7.01	7.02	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
4.00	00400						4.00
5.00	00500	7,323,206	7,323,206				5.00
7.00	00700	346,118	124,273	470,391			7.00
7.01	00701	830,578	298,217	25,397	1,154,192		7.01
7.02	00702	267,741	96,132	4,747	0	368,620	7.02
8.00	00800	73,804	26,499	0	0	0	8.00
9.00	00900	571,801	205,303	12,540	44,477	1,518	9.00
10.00	01000	457,504	164,265	11,282	0	32,347	10.00
11.00	01100	136,328	48,948	11,046	0	31,670	11.00
13.00	01300	759,455	272,680	813	0	2,332	13.00
14.00	01400	212,478	76,290	6,639	24,585	0	14.00
15.00	01500	2,787,737	1,000,933	8,237	30,503	0	15.00
16.00	01600	293,083	105,231	7,452	0	21,366	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,266,937	813,937	79,584	294,705	0	30.00
31.00	03100	221,319	79,464	9,533	35,301	0	31.00
43.00	04300	147,723	53,039	1,920	7,109	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,759,489	631,739	51,172	189,499	0	50.00
52.00	05200	151,360	54,345	3,650	13,518	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	1,100,080	394,980	32,367	119,860	0	54.00
55.00	05500	199,855	71,757	1,943	7,197	0	55.00
56.00	05600	393,293	141,211	1,707	6,321	0	56.00
57.00	05700	423,794	152,162	2,336	8,650	0	57.00
58.00	05800	478,704	171,877	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	1,670,074	599,635	13,368	49,502	0	60.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	579,775	208,166	12,223	45,265	0	66.00
67.00	06700	105,256	37,792	0	0	0	67.00
68.00	06800	86,747	31,146	0	0	0	68.00
69.00	06900	100,311	36,016	1,995	7,389	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	8,645	3,104	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	298,138	107,046	8,857	32,797	0	75.01
75.02	07502	580,976	208,598	7,518	27,842	0	75.02
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	120,899	43,408	0	0	0	90.00
91.00	09100	2,372,818	851,953	38,330	141,941	0	91.00
92.00	09200	0	0	0	0	0	92.00
92.01	09201	270,862	97,252	18,290	67,731	0	92.01
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	0	0	0	0	0	98.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
114.00	11400						114.00
115.00	11500	0	0	0	0	0	115.00
118.00		27,396,888	7,207,398	372,946	1,154,192	89,233	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	60,721	21,802	18,763	0	53,795	192.00
192.01	19201	26,871	9,648	8,303	0	23,806	192.01
192.02	19202	233,025	83,667	70,143	0	201,108	192.02
192.04	19204	1,158	416	0	0	0	192.04
192.05	19205	765	275	236	0	678	192.05
193.00	19300	0	0	0	0	0	193.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		27,719,428	7,323,206	470,391	1,154,192	368,620	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151312

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

Worksheet B
Part I
Date/Time Prepared:
6/30/2014 2:17 pm

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 - HOSPITAL					1.01	
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB					1.02	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT					7.00	
7.01	00701	OPERATION OF PLANT - HOSPITAL					7.01	
7.02	00702	OPERATION OF PLANT - TUMOB					7.02	
8.00	00800	LAUNDRY & LINEN SERVICE	100,303				8.00	
9.00	00900	HOUSEKEEPING	4,265	839,904			9.00	
10.00	01000	DIETARY	985	25,067	691,450		10.00	
11.00	01100	CAFETERIA	0	24,416	0	252,408	11.00	
13.00	01300	NURSING ADMINISTRATION	0	0	0	16,173	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,232	0	3,559	14.00	
15.00	01500	PHARMACY	0	33,206	0	8,293	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	9,684	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	27,499	146,820	675,557	50,805	353,920	30.00
31.00	03100	INTENSIVE CARE UNIT	3,507	43,623	15,893	2,653	18,575	31.00
43.00	04300	NURSERY	1,168	3,581	0	3,164	21,912	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,950	96,361	0	20,798	144,978	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,067	6,511	0	2,902	20,097	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,435	39,065	0	13,758	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	105	2,279	0	1,792	0	55.00
56.00	05600	RADIOISOTOPE	758	1,953	0	3,912	0	56.00
57.00	05700	CT SCAN	2,035	2,930	0	3,960	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	283	0	0	3,517	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	187	51,110	0	27,431	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,159	35,484	0	11,269	78,905	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,747	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,682	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,313	9,055	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	ONCOLOGY	1,799	0	0	5,755	39,933	75.01
75.02	07502	CARDIOPULMONARY	1,237	26,044	0	14,483	101,027	75.02
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	993	39,065	0	5,974	0	90.00
91.00	09100	EMERGENCY	31,211	91,478	0	33,471	233,784	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,660	41,670	0	4,299	29,267	92.01
OTHER REIMBURSABLE COST CENTERS								
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100,303	714,895	691,450	252,394	1,051,453	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	44,274	0	0	0	192.00
192.01	19201	ARNETT SURGERY OFFICE	0	41,670	0	0	0	192.01
192.02	19202	TLMOB	0	39,065	0	0	0	192.02
192.04	19204	OCCUPATIONAL MEDICINE	0	0	0	14	0	192.04
192.05	19205	VENDING ROOM	0	0	0	0	0	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	100,303	839,904	691,450	252,408	1,051,453	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151312

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

Worksheet B
Part I
Date/Time Prepared:
6/30/2014 2:17 pm

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 - HOSPITAL					1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB					1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL					7.01
7.02	00702	OPERATION OF PLANT - TUMOB					7.02
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	327,783				14.00
15.00	01500	PHARMACY	3,073	3,871,982			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	915	0	437,731		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	21,946	0	207,868	4,939,578	0 30.00
31.00	03100	INTENSIVE CARE UNIT	1,636	0	0	431,504	0 31.00
43.00	04300	NURSERY	2,195	0	4,606	246,417	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	91,314	0	52,465	3,053,765	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,013	0	4,229	259,692	0 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,991	0	0	1,707,536	0 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	733	0	0	285,661	0 55.00
56.00	05600	RADIOISOTOPE	1,459	0	0	550,614	0 56.00
57.00	05700	CT SCAN	4,041	0	0	599,908	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	110	0	0	654,491	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00	06000	LABORATORY	131,252	0	0	2,542,559	0 60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	10,857	0	0	983,103	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	573	0	0	145,368	0 67.00
68.00	06800	SPEECH PATHOLOGY	104	0	0	119,679	0 68.00
69.00	06900	ELECTROCARDIOLOGY	3,350	0	0	159,429	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
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	11,749	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,871,982	0	3,871,982	0 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0 74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
75.01	07501	ONCOLOGY	2,683	0	0	497,008	0 75.01
75.02	07502	CARDIOPULMONARY	10,464	0	0	978,189	0 75.02
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,823	0	5,187	218,349	0 90.00
91.00	09100	EMERGENCY	30,092	0	163,376	3,988,454	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,030	0	0	532,061	0 92.01
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0 98.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0 115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	325,654	3,871,982	437,731	26,777,096	0 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
191.00	19100	RESEARCH	0	0	0	0	0 191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	199,355	0 192.00
192.01	19201	ARNETT SURGERY OFFICE	0	0	0	110,298	0 192.01
192.02	19202	TLMOB	2,129	0	0	629,137	0 192.02
192.04	19204	OCCUPATIONAL MEDICINE	0	0	0	1,588	0 192.04
192.05	19205	VENDING ROOM	0	0	0	1,954	0 192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	0 193.00
200.00		Cross Foot Adjustments					0 200.00
201.00		Negative Cost Centers	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118-201)	327,783	3,871,982	437,731	27,719,428	0 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151312

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

Worksheet B
Part I
Date/Time Prepared:
6/30/2014 2:17 pm

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 - HOSPITAL	1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	7.01
7.02	00702	OPERATION OF PLANT - TUMOB	7.02
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
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
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
74.00	07400	RENAL DIALYSIS	74.00
75.00	07500	ASC (NON-DISTINCT PART)	75.00
75.01	07501	ONCOLOGY	75.01
75.02	07502	CARDIOPULMONARY	75.02
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
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
114.00	11400	UTILIZATION REVIEW-SNF	114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	ARNETT SURGERY OFFICE	192.01
192.02	19202	TLMOB	192.02
192.04	19204	OCCUPATIONAL MEDICINE	192.04
192.05	19205	VENDING ROOM	192.05
193.00	19300	NONPAID WORKERS	193.00
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: 151312

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

Worksheet B
Part II
Date/Time Prepared:
6/30/2014 2:17 pm

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
			BLDG & FIXT	BLDG & FIXT - HOSPITAL	BLDG & FIXT - TLMOB		
		0	1.00	1.01	1.02	2A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL					1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB					1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	22,550	182,828	124,135	329,513
7.00	00700	OPERATION OF PLANT	0	0	0	0	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	8,730	139,303	23,470	171,503
7.02	00702	OPERATION OF PLANT - TUMOB	0	1,632	0	13,732	15,364
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	4,311	96,807	1,532	102,650
10.00	01000	DIETARY	0	3,878	0	32,634	36,512
11.00	01100	CAFETERIA	0	3,797	0	31,950	35,747
13.00	01300	NURSING ADMINISTRATION	0	280	0	2,352	2,632
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,282	53,511	0	55,793
15.00	01500	PHARMACY	0	2,832	66,393	0	69,225
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,562	0	21,555	24,117
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	27,355	641,439	0	668,794
31.00	03100	INTENSIVE CARE UNIT	0	3,277	76,836	0	80,113
43.00	04300	NURSERY	0	660	15,474	0	16,134
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	17,590	412,458	0	430,048
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,255	29,423	0	30,678
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,126	260,883	0	272,009
55.00	05500	RADIOLOGY-THERAPEUTIC	0	668	15,664	0	16,332
56.00	05600	RADIOISOTOPE	0	587	13,759	0	14,346
57.00	05700	CT SCAN	0	803	18,828	0	19,631
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	4,595	107,745	0	112,340
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	4,202	98,522	0	102,724
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	686	16,084	0	16,770
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	07501	ONCOLOGY	0	3,044	71,386	0	74,430
75.02	07502	CARDIOPULMONARY	0	2,584	60,600	0	63,184
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	13,176	308,944	0	322,120
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	6,287	147,421	0	153,708
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	150,749	2,834,308	251,360	3,236,417
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,450	0	54,271	60,721
192.01	19201	ARNETT SURGERY OFFICE	0	2,854	0	24,017	26,871
192.02	19202	TLMOB	0	24,112	0	202,889	227,001
192.04	19204	OCCUPATIONAL MEDICINE	0	0	0	0	192.04
192.05	19205	VENDING ROOM	0	81	0	684	765
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118-201)	0	184,246	2,834,308	533,221	3,551,775

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151312	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 6/30/2014 2:17 pm			
Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT 4.00	ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	OPERATION OF PLANT - HOSPITAL 7.01	OPERATION OF PLANT - TUMOB 7.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL					1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB					1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	329,513			5.00
7.00	00700	OPERATION OF PLANT	0	5,592	5,592		7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	13,419	302	185,224	7.01
7.02	00702	OPERATION OF PLANT - TUMOB	0	4,326	56	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,192	0	0	8.00
9.00	00900	HOUSEKEEPING	0	9,238	149	7,138	9.00
10.00	01000	DIETARY	0	7,391	134	0	10.00
11.00	01100	CAFETERIA	0	2,203	131	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	12,270	10	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,433	79	3,945	14.00
15.00	01500	PHARMACY	0	45,028	98	4,895	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,735	89	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	36,625	947	47,295	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,576	113	5,665	31.00
43.00	04300	NURSERY	0	2,387	23	1,141	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	28,426	608	30,411	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,445	43	2,169	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,773	385	19,235	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	3,229	23	1,155	55.00
56.00	05600	RADIOISOTOPE	0	6,354	20	1,014	56.00
57.00	05700	CT SCAN	0	6,847	28	1,388	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	7,734	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	26,982	159	7,944	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	9,367	145	7,264	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,701	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,401	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,621	24	1,186	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	140	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	07501	ONCOLOGY	0	4,817	105	5,263	75.01
75.02	07502	CARDIOPULMONARY	0	9,386	89	4,468	75.02
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	1,953	0	0	90.00
91.00	09100	EMERGENCY	0	38,335	456	22,779	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0				92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	4,376	217	10,869	92.01
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	324,302	4,433	185,224	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	981	223	0	192.00
192.01	19201	ARNETT SURGERY OFFICE	0	434	99	0	192.01
192.02	19202	TLMOB	0	3,765	834	0	192.02
192.04	19204	OCCUPATIONAL MEDICINE	0	19	0	0	192.04
192.05	19205	VENDING ROOM	0	12	3	0	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
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)	0	329,513	5,592	185,224	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151312

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

Worksheet B
Part II
Date/Time Prepared:
6/30/2014 2:17 pm

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						1.00
1.01	00101						1.01
1.02	00102						1.02
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
7.01	00701						7.01
7.02	00702						7.02
8.00	00800						8.00
9.00	00900	1,192					9.00
10.00	01000		119,307				10.00
11.00	01100		3,561	49,343			11.00
13.00	01300		3,468		43,245		13.00
14.00	01400				2,771	17,808	14.00
15.00	01500		601		610		15.00
16.00	01600		4,717		1,421		16.00
					1,659		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	327	20,857	48,209	8,705	5,996	30.00
31.00	03100	42	6,197	1,134	455	315	31.00
43.00	04300	14	509	0	542	371	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	190	13,688	0	3,563	2,455	50.00
52.00	05200	13	925	0	497	340	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	53	5,549	0	2,357	0	54.00
55.00	05500	1	324	0	307	0	55.00
56.00	05600	9	277	0	670	0	56.00
57.00	05700	24	416	0	678	0	57.00
58.00	05800	3	0	0	603	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	2	7,260	0	4,700	0	60.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	14	5,040	0	1,931	1,336	66.00
67.00	06700	0	0	0	299	0	67.00
68.00	06800	0	0	0	288	0	68.00
69.00	06900	0	0	0	225	153	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	21	0	0	986	676	75.01
75.02	07502	15	3,699	0	2,481	1,711	75.02
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	12	5,549	0	1,024	0	90.00
91.00	09100	369	12,994	0	5,734	3,959	91.00
92.00	09200						92.00
92.01	09201	20	5,919	0	737	496	92.01
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	0	0	0	0	0	98.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
114.00	11400						114.00
115.00	11500	0	0	0	0	0	115.00
118.00		1,192	101,550	49,343	43,243	17,808	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	6,289	0	0	0	192.00
192.01	19201	0	5,919	0	0	0	192.01
192.02	19202	0	5,549	0	0	0	192.02
192.04	19204	0	0	0	2	0	192.04
192.05	19205	0	0	0	0	0	192.05
193.00	19300	0	0	0	0	0	193.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,192	119,307	49,343	43,245	17,808	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151312

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

Worksheet B
Part II
Date/Time Prepared:
6/30/2014 2:17 pm

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						1.00
1.01	00101						1.01
1.02	00102						1.02
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
7.01	00701						7.01
7.02	00702						7.02
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	64,461					14.00
15.00	01500	604	125,988				15.00
16.00	01600	180	0	31,925			16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	4,316	0	15,161	857,232	0	30.00
31.00	03100	322	0	0	97,932	0	31.00
43.00	04300	432	0	336	21,889	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	17,958	0	3,826	531,173	0	50.00
52.00	05200	396	0	308	37,814	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	588	0	0	317,949	0	54.00
55.00	05500	144	0	0	21,515	0	55.00
56.00	05600	287	0	0	22,977	0	56.00
57.00	05700	795	0	0	29,807	0	57.00
58.00	05800	22	0	0	8,362	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	25,809	0	0	185,196	0	60.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	2,135	0	0	129,956	0	66.00
67.00	06700	113	0	0	2,113	0	67.00
68.00	06800	20	0	0	1,709	0	68.00
69.00	06900	659	0	0	20,638	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	140	0	72.00
73.00	07300	0	125,988	0	125,988	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	528	0	0	86,826	0	75.01
75.02	07502	2,058	0	0	87,091	0	75.02
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	555	0	378	9,471	0	90.00
91.00	09100	5,918	0	11,916	424,580	0	91.00
92.00	09200						92.00
92.01	09201	203	0	0	176,545	0	92.01
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	0	0	0	0	0	98.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
114.00	11400						114.00
115.00	11500	0	0	0	0	0	115.00
118.00		64,042	125,988	31,925	3,196,903	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	71,096	0	192.00
192.01	19201	0	0	0	34,598	0	192.01
192.02	19202	419	0	0	248,341	0	192.02
192.04	19204	0	0	0	21	0	192.04
192.05	19205	0	0	0	816	0	192.05
193.00	19300	0	0	0	0	0	193.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		64,461	125,988	31,925	3,551,775	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151312	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 6/30/2014 2:17 pm
-------------------------------------	--	----------------------	---	--

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 - HOSPITAL	1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	7.01
7.02	00702	OPERATION OF PLANT - TUMOB	7.02
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
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
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
74.00	07400	RENAL DIALYSIS	74.00
75.00	07500	ASC (NON-DISTINCT PART)	75.00
75.01	07501	ONCOLOGY	75.01
75.02	07502	CARDIOPULMONARY	75.02
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
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
114.00	11400	UTILIZATION REVIEW-SNF	114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	ARNETT SURGERY OFFICE	192.01
192.02	19202	TLMOB	192.02
192.04	19204	OCCUPATIONAL MEDICINE	192.04
192.05	19205	VENDING ROOM	192.05
193.00	19300	NONPAID WORKERS	193.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151312

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

Worksheet B-1

Date/Time Prepared:
6/30/2014 2:17 pm

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
		BLDG & FIXT (SQUARE FEET)	BLDG & FIXT - HOSPITAL (SQUARE FEET)	BLDG & FIXT - TLMOB (SQUARE FEET)			
		1.00	1.01	1.02			
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	113,352				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	74,366			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	38,986		1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	9,039,612	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,873	4,797	9,076	1,355,939	-7,323,206
7.00	00700	OPERATION OF PLANT	0	0	0	154,819	0
7.01	00701	OPERATION OF PLANT - HOSPITAL	5,371	3,655	1,716	0	0
7.02	00702	OPERATION OF PLANT - TUMOB	1,004	0	1,004	0	0
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0
9.00	00900	HOUSEKEEPING	2,652	2,540	112	282,854	0
10.00	01000	DIETARY	2,386	0	2,386	246,905	0
11.00	01100	CAFETERIA	2,336	0	2,336	94,398	0
13.00	01300	NURSING ADMINISTRATION	172	0	172	565,435	0
14.00	01400	CENTRAL SERVICES & SUPPLY	1,404	1,404	0	75,865	0
15.00	01500	PHARMACY	1,742	1,742	0	365,015	0
16.00	01600	MEDICAL RECORDS & LIBRARY	1,576	0	1,576	196,867	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	16,830	16,830	0	1,132,049	0
31.00	03100	INTENSIVE CARE UNIT	2,016	2,016	0	89,032	0
43.00	04300	NURSERY	406	406	0	90,135	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,822	10,822	0	733,732	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	772	772	0	82,664	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,845	6,845	0	362,738	0
55.00	05500	RADIOLOGY-THERAPEUTIC	411	411	0	56,884	0
56.00	05600	RADIOISOTOPE	361	361	0	153,996	0
57.00	05700	CT SCAN	494	494	0	142,681	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	96,434	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	2,827	2,827	0	627,387	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	2,585	2,585	0	350,429	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	81,639	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	67,600	0
69.00	06900	ELECTROCARDIOLOGY	422	422	0	30,104	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
75.01	07501	ONCOLOGY	1,873	1,873	0	159,095	0
75.02	07502	CARDIOPULMONARY	1,590	1,590	0	366,081	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	79,747	0
91.00	09100	EMERGENCY	8,106	8,106	0	908,283	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	3,868	3,868	0	90,478	0
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	92,744	74,366	18,378	9,039,285	-7,323,206
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,968	0	3,968	0	0
192.01	19201	ARNETT SURGERY OFFICE	1,756	0	1,756	0	0
192.02	19202	TLMOB	14,834	0	14,834	0	0
192.04	19204	OCCUPATIONAL MEDICINE	0	0	0	327	0
192.05	19205	VENDING ROOM	50	0	50	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151312

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

Worksheet B-1

Date/Time Prepared:
6/30/2014 2:17 pm

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
		BLDG & FIXT (SQUARE FEET)	BLDG & FIXT - HOSPITAL (SQUARE FEET)	BLDG & FIXT - TLMOB (SQUARE FEET)			
		1.00	1.01	1.02			
202.00	Cost to be allocated (per Wkst. B, Part I)	184,246	2,834,308	533,221	2,380,288	5A	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1.625432	38.112955	13.677243	0.263317		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)				0.000000		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151312

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

Worksheet B-1
Date/Time Prepared:
6/30/2014 2:17 pm

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL (SQUARE FEET)	OPERATION OF PLANT - TUMOB (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		5.00	7.00	7.01	7.02	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL					1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB					1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,396,222				5.00
7.00	00700	OPERATION OF PLANT	346,118	99,479			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	830,578	5,371	65,914		7.01
7.02	00702	OPERATION OF PLANT - TUMOB	267,741	1,004	0	27,190	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	73,804	0	0	23,023	8.00
9.00	00900	HOUSEKEEPING	571,801	2,652	2,540	112	979
10.00	01000	DIETARY	457,504	2,386	0	2,386	226
11.00	01100	CAFETERIA	136,328	2,336	0	2,336	0
13.00	01300	NURSING ADMINISTRATION	759,455	172	0	172	0
14.00	01400	CENTRAL SERVICES & SUPPLY	212,478	1,404	1,404	0	0
15.00	01500	PHARMACY	2,787,737	1,742	1,742	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	293,083	1,576	0	1,576	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,266,937	16,830	16,830	0	6,312
31.00	03100	INTENSIVE CARE UNIT	221,319	2,016	2,016	0	805
43.00	04300	NURSERY	147,723	406	406	0	268
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,759,489	10,822	10,822	0	3,661
52.00	05200	DELIVERY ROOM & LABOR ROOM	151,360	772	772	0	245
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,100,080	6,845	6,845	0	1,018
55.00	05500	RADIOLOGY-THERAPEUTIC	199,855	411	411	0	24
56.00	05600	RADIOISOTOPE	393,293	361	361	0	174
57.00	05700	CT SCAN	423,794	494	494	0	467
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	478,704	0	0	0	65
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	1,670,074	2,827	2,827	0	43
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	579,775	2,585	2,585	0	266
67.00	06700	OCCUPATIONAL THERAPY	105,256	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	86,747	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	100,311	422	422	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,645	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
75.01	07501	ONCOLOGY	298,138	1,873	1,873	0	413
75.02	07502	CARDIOPULMONARY	580,976	1,590	1,590	0	284
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	120,899	0	0	0	228
91.00	09100	EMERGENCY	2,372,818	8,106	8,106	0	7,164
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	270,862	3,868	3,868	0	381
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
114.00	11400	UTILIZATION REVIEW-SNF					
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,073,682	78,871	65,914	6,582	23,023
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	60,721	3,968	0	3,968	0
192.01	19201	ARNETT SURGERY OFFICE	26,871	1,756	0	1,756	0
192.02	19202	TLMOB	233,025	14,834	0	14,834	0
192.04	19204	OCCUPATIONAL MEDICINE	1,158	0	0	0	0
192.05	19205	VENDING ROOM	765	50	0	50	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	7,323,206	470,391	1,154,192	368,620	100,303
203.00		Unit cost multiplier (Wkst. B, Part I)	0.359047	4.728546	17.510574	13.557190	4.356643

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 151312		Period: From 01/01/2013 To 12/31/2013		Worksheet B-1 Date/Time Prepared: 6/30/2014 2:17 pm	
Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL (SQUARE FEET)	OPERATION OF PLANT - TUMOB (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		5.00	7.00	7.01	7.02	8.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	329,513	5,592	185,224	19,746	1,192	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.016156	0.056213	2.810086	0.726223	0.051774	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151312

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

Worksheet B-1

Date/Time Prepared:
6/30/2014 2:17 pm

Cost Center Description		HOUSEKEEPING (TIME SPENT)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIREMENTS)	
		9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
7.01	00701						7.01
7.02	00702						7.02
8.00	00800						8.00
9.00	00900	2,580					9.00
10.00	01000	77	12,530				10.00
11.00	01100	75	0	162,407			11.00
13.00	01300	0	0	10,406	165,118		13.00
14.00	01400	13	0	2,290	0	907,319	14.00
15.00	01500	102	0	5,336	0	8,507	15.00
16.00	01600	0	0	6,231	0	2,533	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	451	12,242	32,690	55,579	60,749	30.00
31.00	03100	134	288	1,707	2,917	4,529	31.00
43.00	04300	11	0	2,036	3,441	6,075	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	296	0	13,382	22,767	252,761	50.00
52.00	05200	20	0	1,867	3,156	5,573	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	120	0	8,852	0	8,278	54.00
55.00	05500	7	0	1,153	0	2,030	55.00
56.00	05600	6	0	2,517	0	4,039	56.00
57.00	05700	9	0	2,548	0	11,186	57.00
58.00	05800	0	0	2,263	0	304	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	157	0	17,650	0	363,308	60.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	109	0	7,251	12,391	30,053	66.00
67.00	06700	0	0	1,124	0	1,587	67.00
68.00	06800	0	0	1,082	0	287	68.00
69.00	06900	0	0	845	1,422	9,274	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	0	0	3,703	6,271	7,428	75.01
75.02	07502	80	0	9,319	15,865	28,965	75.02
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	120	0	3,844	0	7,813	90.00
91.00	09100	281	0	21,536	36,713	83,296	91.00
92.00	09200						92.00
92.01	09201	128	0	2,766	4,596	2,851	92.01
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	0	0	0	0	0	98.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
114.00	11400						114.00
115.00	11500	0	0	0	0	0	115.00
118.00		2,196	12,530	162,398	165,118	901,426	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	136	0	0	0	0	192.00
192.01	19201	128	0	0	0	0	192.01
192.02	19202	120	0	0	0	5,893	192.02
192.04	19204	0	0	9	0	0	192.04
192.05	19205	0	0	0	0	0	192.05
193.00	19300	0	0	0	0	0	193.00
200.00							200.00
201.00							201.00
202.00		839,904	691,450	252,408	1,051,453	327,783	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151312

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

Worksheet B-1

Date/Time Prepared:
6/30/2014 2:17 pm

Cost Center Description		HOUSEKEEPING (TIME SPENT)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIREMENTS)	
		9.00	10.00	11.00	13.00	14.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	325.544186	55.183559	1.554169	6.367888	0.361265	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	119,307	49,343	43,245	17,808	64,461	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	46.243023	3.937989	0.266275	0.107850	0.071046	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151312

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

Worksheet B-1
Date/Time Prepared:
6/30/2014 2:17 pm

Cost Center Description		PHARMACY (COSTED REQUIREMENTS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		15.00	16.00	
GENERAL SERVICE COST CENTERS				
1.00	00100			1.00
1.01	00101			1.01
1.02	00102			1.02
4.00	00400			4.00
5.00	00500			5.00
7.00	00700			7.00
7.01	00701			7.01
7.02	00702			7.02
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	100		15.00
16.00	01600	0	45,237	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	0	21,482	30.00
31.00	03100	0	0	31.00
43.00	04300	0	476	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	0	5,422	50.00
52.00	05200	0	437	52.00
53.00	05300	0	0	53.00
54.00	05400	0	0	54.00
55.00	05500	0	0	55.00
56.00	05600	0	0	56.00
57.00	05700	0	0	57.00
58.00	05800	0	0	58.00
59.00	05900	0	0	59.00
60.00	06000	0	0	60.00
65.00	06500	0	0	65.00
66.00	06600	0	0	66.00
67.00	06700	0	0	67.00
68.00	06800	0	0	68.00
69.00	06900	0	0	69.00
70.00	07000	0	0	70.00
71.00	07100	0	0	71.00
72.00	07200	0	0	72.00
73.00	07300	100	0	73.00
74.00	07400	0	0	74.00
75.00	07500	0	0	75.00
75.01	07501	0	0	75.01
75.02	07502	0	0	75.02
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	0	536	90.00
91.00	09100	0	16,884	91.00
92.00	09200	0	0	92.00
92.01	09201	0	0	92.01
OTHER REIMBURSABLE COST CENTERS				
98.00	05950	0	0	98.00
101.00	10100	0	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	0	0	113.00
114.00	11400	0	0	114.00
115.00	11500	0	0	115.00
118.00		100	45,237	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	0	0	190.00
191.00	19100	0	0	191.00
192.00	19200	0	0	192.00
192.01	19201	0	0	192.01
192.02	19202	0	0	192.02
192.04	19204	0	0	192.04
192.05	19205	0	0	192.05
193.00	19300	0	0	193.00
200.00				200.00
201.00				201.00
202.00		3,871,982	437,731	202.00
203.00		38,719.820000	9.676393	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151312

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

Worksheet B-1

Date/Time Prepared:
6/30/2014 2:17 pm

Cost Center Description		PHARMACY (COSTED REQUIREMENTS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		15.00	16.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	125,988	31,925	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1,259.880000	0.705728	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151312

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

Worksheet C
Part I
Date/Time Prepared:
6/30/2014 2:17 pm

		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		4,939,578	0	0	30.00	
31.00	03100 INTENSIVE CARE UNIT		431,504	0	0	31.00	
43.00	04300 NURSERY		246,417	0	0	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		3,053,765	0	0	50.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM		259,692	0	0	52.00	
53.00	05300 ANESTHESIOLOGY		0	0	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		1,707,536	0	0	54.00	
55.00	05500 RADIOLOGY-THERAPEUTIC		285,661	0	0	55.00	
56.00	05600 RADIOISOTOPE		550,614	0	0	56.00	
57.00	05700 CT SCAN		599,908	0	0	57.00	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		654,491	0	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00	
60.00	06000 LABORATORY		2,542,559	0	0	60.00	
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	65.00	
66.00	06600 PHYSICAL THERAPY	0	983,103	0	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	145,368	0	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0	119,679	0	0	68.00	
69.00	06900 ELECTROCARDIOLOGY		159,429	0	0	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY		0	0	0	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		11,749	0	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		3,871,982	0	0	73.00	
74.00	07400 RENAL DIALYSIS		0	0	0	74.00	
75.00	07500 ASC (NON-DISTINCT PART)		0	0	0	75.00	
75.01	07501 ONCOLOGY		497,008	0	0	75.01	
75.02	07502 CARDIOPULMONARY		978,189	0	0	75.02	
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC		218,349	0	0	90.00	
91.00	09100 EMERGENCY		3,988,454	0	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	92.00	
92.01	09201 OBSERVATION BEDS (DISTINCT PART)		532,061	0	0	92.01	
OTHER REIMBURSABLE COST CENTERS							
98.00	05950 OTHER REIMBURSABLE COST CENTERS		0	0	0	98.00	
101.00	10100 HOME HEALTH AGENCY		0	0	0	101.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE					113.00	
114.00	11400 UTILIZATION REVIEW-SNF					114.00	
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)		0	0	0	115.00	
200.00	Subtotal (see instructions)		26,777,096	0	0	200.00	
201.00	Less Observation Beds		0	0	0	201.00	
202.00	Total (see instructions)		26,777,096	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151312

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

Worksheet C
Part I
Date/Time Prepared:
6/30/2014 2:17 pm

		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	3,046,487		3,046,487		30.00
31.00	03100	INTENSIVE CARE UNIT	161,018		161,018		31.00
43.00	04300	NURSERY	211,953		211,953		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	763,346	4,207,383	4,970,729	0.614350	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	179,510	23,644	203,154	1.278301	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	135,549	3,850,474	3,986,023	0.428381	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	31,625	469,868	501,493	0.569621	55.00
56.00	05600	RADIOISOTOPE	222,220	1,976,538	2,198,758	0.250420	56.00
57.00	05700	CT SCAN	315,727	9,506,688	9,822,415	0.061075	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	77,256	1,523,244	1,600,500	0.408929	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	997,838	6,439,922	7,437,760	0.341845	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	308,530	991,708	1,300,238	0.756095	66.00
67.00	06700	OCCUPATIONAL THERAPY	85,285	111,963	197,248	0.736981	67.00
68.00	06800	SPEECH PATHOLOGY	15,573	109,677	125,250	0.955521	68.00
69.00	06900	ELECTROCARDIOLOGY	93,307	1,494,811	1,588,118	0.100389	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,258	25,065	26,323	0.446340	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,305,043	8,581,370	9,886,413	0.391647	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	75.00
75.01	07501	ONCOLOGY	2,127	698,545	700,672	0.709330	75.01
75.02	07502	CARDIOPULMONARY	719,621	386,308	1,105,929	0.884495	75.02
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	549	40,170	40,719	5.362337	90.00
91.00	09100	EMERGENCY	44,857	8,580,829	8,625,686	0.462393	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	696,093	696,093	0.764353	92.01
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0.000000	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0		115.00
200.00		Subtotal (see instructions)	8,718,679	49,714,300	58,432,979		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	8,718,679	49,714,300	58,432,979		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151312	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 6/30/2014 2:17 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital Cost
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO 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
74.00	07400 RENAL DIALYSIS	0.000000		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000		75.00
75.01	07501 ONCOLOGY	0.000000		75.01
75.02	07502 CARDIOPULMONARY	0.000000		75.02
	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
101.00	10100 HOME HEALTH AGENCY			101.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
114.00	11400 UTILIZATION REVIEW-SNF			114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)			115.00
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: 151312

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

Worksheet C
Part I
Date/Time Prepared:
6/30/2014 2:17 pm

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS		4,939,578		0	4,939,578	30.00
31.00	03100 INTENSIVE CARE UNIT		431,504		0	431,504	31.00
43.00	04300 NURSERY		246,417		0	246,417	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		3,053,765		0	3,053,765	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		259,692		0	259,692	52.00
53.00	05300 ANESTHESIOLOGY		0		0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		1,707,536		0	1,707,536	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC		285,661		0	285,661	55.00
56.00	05600 RADIOISOTOPE		550,614		0	550,614	56.00
57.00	05700 CT SCAN		599,908		0	599,908	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		654,491		0	654,491	58.00
59.00	05900 CARDIAC CATHETERIZATION		0		0	0	59.00
60.00	06000 LABORATORY		2,542,559		0	2,542,559	60.00
65.00	06500 RESPIRATORY THERAPY	0	0		0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	983,103		0	983,103	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	145,368		0	145,368	67.00
68.00	06800 SPEECH PATHOLOGY	0	119,679		0	119,679	68.00
69.00	06900 ELECTROCARDIOLOGY		159,429		0	159,429	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		0		0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0		0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		11,749		0	11,749	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		3,871,982		0	3,871,982	73.00
74.00	07400 RENAL DIALYSIS		0		0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)		0		0	0	75.00
75.01	07501 ONCOLOGY		497,008		0	497,008	75.01
75.02	07502 CARDIOPULMONARY		978,189		0	978,189	75.02
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC		218,349		0	218,349	90.00
91.00	09100 EMERGENCY		3,988,454		0	3,988,454	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0		0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)		532,061		0	532,061	92.01
OTHER REIMBURSABLE COST CENTERS							
98.00	05950 OTHER REIMBURSABLE COST CENTERS		0		0	0	98.00
101.00	10100 HOME HEALTH AGENCY		0		0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
114.00	11400 UTILIZATION REVIEW-SNF						114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)		0		0	0	115.00
200.00	Subtotal (see instructions)		26,777,096	0	0	26,777,096	200.00
201.00	Less Observation Beds		0		0	0	201.00
202.00	Total (see instructions)		26,777,096	0	0	26,777,096	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151312

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

Worksheet C
Part I
Date/Time Prepared:
6/30/2014 2:17 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,046,487		3,046,487		30.00
31.00	03100	INTENSIVE CARE UNIT	161,018		161,018		31.00
43.00	04300	NURSERY	211,953		211,953		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	763,346	4,207,383	4,970,729	0.614350	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	179,510	23,644	203,154	1.278301	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	135,549	3,850,474	3,986,023	0.428381	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	31,625	469,868	501,493	0.569621	55.00
56.00	05600	RADIOISOTOPE	222,220	1,976,538	2,198,758	0.250420	56.00
57.00	05700	CT SCAN	315,727	9,506,688	9,822,415	0.061075	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	77,256	1,523,244	1,600,500	0.408929	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	997,838	6,439,922	7,437,760	0.341845	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	308,530	991,708	1,300,238	0.756095	66.00
67.00	06700	OCCUPATIONAL THERAPY	85,285	111,963	197,248	0.736981	67.00
68.00	06800	SPEECH PATHOLOGY	15,573	109,677	125,250	0.955521	68.00
69.00	06900	ELECTROCARDIOLOGY	93,307	1,494,811	1,588,118	0.100389	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,258	25,065	26,323	0.446340	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,305,043	8,581,370	9,886,413	0.391647	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	75.00
75.01	07501	ONCOLOGY	2,127	698,545	700,672	0.709330	75.01
75.02	07502	CARDIOPULMONARY	719,621	386,308	1,105,929	0.884495	75.02
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	549	40,170	40,719	5.362337	90.00
91.00	09100	EMERGENCY	44,857	8,580,829	8,625,686	0.462393	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	696,093	696,093	0.764353	92.01
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0.000000	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0		115.00
200.00		Subtotal (see instructions)	8,718,679	49,714,300	58,432,979		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	8,718,679	49,714,300	58,432,979		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151312	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 6/30/2014 2:17 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO 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
74.00	07400 RENAL DIALYSIS	0.000000		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000		75.00
75.01	07501 ONCOLOGY	0.000000		75.01
75.02	07502 CARDIOPULMONARY	0.000000		75.02
	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
101.00	10100 HOME HEALTH AGENCY			101.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
114.00	11400 UTILIZATION REVIEW-SNF			114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)			115.00
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: 151312	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 6/30/2014 2:17 pm
--	--	----------------------	---	--

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	531,173	4,970,729	0.106860	168,333	17,988	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	37,814	203,154	0.186135	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	317,949	3,986,023	0.079766	76,226	6,080	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	21,515	501,493	0.042902	19,722	846	55.00
56.00	05600 RADIOISOTOPE	22,977	2,198,758	0.010450	150,399	1,572	56.00
57.00	05700 CT SCAN	29,807	9,822,415	0.003035	234,400	711	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	8,362	1,600,500	0.005225	54,237	283	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	185,196	7,437,760	0.024899	484,204	12,056	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0.000000	0	0	65.00
66.00	06600 PHYSICAL THERAPY	129,956	1,300,238	0.099948	104,145	10,409	66.00
67.00	06700 OCCUPATIONAL THERAPY	2,113	197,248	0.010712	24,895	267	67.00
68.00	06800 SPEECH PATHOLOGY	1,709	125,250	0.013645	5,942	81	68.00
69.00	06900 ELECTROCARDIOLOGY	20,638	1,588,118	0.012995	62,538	813	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	140	26,323	0.005319	1,110	6	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	125,988	9,886,413	0.012744	515,171	6,565	73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	07501 ONCOLOGY	86,826	700,672	0.123918	0	0	75.01
75.02	07502 CARDIOPULMONARY	87,091	1,105,929	0.078749	397,305	31,287	75.02
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	9,471	40,719	0.232594	485	113	90.00
91.00	09100 EMERGENCY	424,580	8,625,686	0.049223	10,156	500	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)	176,545	696,093	0.253623	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)	2,219,850	55,013,521		2,309,268	89,577	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151312	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 6/30/2014 2:17 pm
--	----------------------	---	--

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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	0	75.00
75.01	07501	ONCOLOGY	0	0	0	0	0	0	75.01
75.02	07502	CARDIOPULMONARY	0	0	0	0	0	0	75.02
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: 151312	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 6/30/2014 2:17 pm
--	----------------------	---------------------------------------	---

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	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	4,970,729	0.000000	0.000000	168,333	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	203,154	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	3,986,023	0.000000	0.000000	76,226	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	501,493	0.000000	0.000000	19,722	55.00
56.00	05600 RADIOISOTOPE	0	2,198,758	0.000000	0.000000	150,399	56.00
57.00	05700 CT SCAN	0	9,822,415	0.000000	0.000000	234,400	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1,600,500	0.000000	0.000000	54,237	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	7,437,760	0.000000	0.000000	484,204	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0.000000	0.000000	0	65.00
66.00	06600 PHYSICAL THERAPY	0	1,300,238	0.000000	0.000000	104,145	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	197,248	0.000000	0.000000	24,895	67.00
68.00	06800 SPEECH PATHOLOGY	0	125,250	0.000000	0.000000	5,942	68.00
69.00	06900 ELECTROCARDIOLOGY	0	1,588,118	0.000000	0.000000	62,538	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	26,323	0.000000	0.000000	1,110	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	9,886,413	0.000000	0.000000	515,171	73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
75.01	07501 ONCOLOGY	0	700,672	0.000000	0.000000	0	75.01
75.02	07502 CARDIOPULMONARY	0	1,105,929	0.000000	0.000000	397,305	75.02
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	40,719	0.000000	0.000000	485	90.00
91.00	09100 EMERGENCY	0	8,625,686	0.000000	0.000000	10,156	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	696,093	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	55,013,521			2,309,268	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151312	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 6/30/2014 2:17 pm
--	----------------------	---	--

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	Cost
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0		55.00
56.00	05600 RADIOISOTOPE	0	0	0		56.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO 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
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	07501 ONCOLOGY	0	0	0		75.01
75.02	07502 CARDIOPULMONARY	0	0	0		75.02
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: 151312	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 6/30/2014 2:17 pm
		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	0.614350	0	1,627,429	0	0 50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1.278301	0	0	0	0 52.00
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.428381	0	1,298,462	0	0 54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0.569621	0	202,927	0	0 55.00
56.00 05600 RADIOISOTOPE	0.250420	0	686,758	0	0 56.00
57.00 05700 CT SCAN	0.061075	0	3,563,631	0	0 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.408929	0	577,445	0	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0 59.00
60.00 06000 LABORATORY	0.341845	0	2,567,953	0	0 60.00
65.00 06500 RESPIRATORY THERAPY	0.000000	0	0	0	0 65.00
66.00 06600 PHYSICAL THERAPY	0.756095	0	412,342	0	0 66.00
67.00 06700 OCCUPATIONAL THERAPY	0.736981	0	35,827	0	0 67.00
68.00 06800 SPEECH PATHOLOGY	0.955521	0	8,538	0	0 68.00
69.00 06900 ELECTROCARDIOLOGY	0.100389	0	638,590	0	0 69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.446340	0	14,604	0	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.391647	0	4,029,473	1,002	0 73.00
74.00 07400 RENAL DIALYSIS	0.000000	0	0	0	0 74.00
75.00 07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0 75.00
75.01 07501 ONCOLOGY	0.709330	0	304,582	0	0 75.01
75.02 07502 CARDIOPULMONARY	0.884495	0	171,421	0	0 75.02
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	5.362337	0	27,413	0	0 90.00
91.00 09100 EMERGENCY	0.462393	0	2,336,092	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)	0.764353	0	462,153	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	18,965,640	1,002	0 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0	0 201.00
202.00	Net Charges (line 200 +/- line 201)	0	18,965,640	1,002	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151312	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 6/30/2014 2:17 pm
	Title XVIII	Hospital	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	999,811	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	556,236	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	115,591	0	55.00
56.00	05600 RADIOISOTOPE	171,978	0	56.00
57.00	05700 CT SCAN	217,649	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	236,134	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	877,842	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	311,770	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	26,404	0	67.00
68.00	06800 SPEECH PATHOLOGY	8,158	0	68.00
69.00	06900 ELECTROCARDIOLOGY	64,107	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	6,518	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,578,131	392	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	75.00
75.01	07501 ONCOLOGY	216,049	0	75.01
75.02	07502 CARDIOPULMONARY	151,621	0	75.02
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	146,998	0	90.00
91.00	09100 EMERGENCY	1,080,193	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	353,248	0	92.01
OTHER REIMBURSABLE COST CENTERS				
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	98.00
200.00	Subtotal (see instructions)	7,118,438	392	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	7,118,438	392	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151312

Period: From 01/01/2013

Worksheet D

Component CCN: 15Z312

To 12/31/2013

Part V
Date/Time Prepared:
6/30/2014 2:17 pm

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	0.614350	0	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1.278301	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.428381	0	0	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0.569621	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0.250420	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0.061075	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.408929	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0.341845	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.756095	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.736981	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.955521	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.100389	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.446340	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.391647	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	0	75.00
75.01 07501 ONCOLOGY	0.709330	0	0	0	0	0	75.01
75.02 07502 CARDIOPULMONARY	0.884495	0	0	0	0	0	75.02
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	5.362337	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0.462393	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0.764353	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
98.00 05950 OTHER REIMBURSABLE COST CENTERS	0.000000	0	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	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: 151312	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 6/30/2014 2:17 pm
		Component CCN: 15Z312		
		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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
75.01	07501	ONCOLOGY	0	0	75.01
75.02	07502	CARDIOPULMONARY	0	0	75.02
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	0	201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151312

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

Worksheet D
Part IV
Date/Time Prepared:
6/30/2014 2:17 pm

Cost Center Description		Title XIX				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	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	ONCOLOGY	0	0	0	0	0	75.01
75.02	07502	CARDIOPULMONARY	0	0	0	0	0	75.02
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151312

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

Worksheet D
Part IV
Date/Time Prepared:
6/30/2014 2:17 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	Cost
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)			
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	4,970,729	0.000000	0.000000	40,525	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	203,154	0.000000	0.000000	9,530	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,986,023	0.000000	0.000000	7,196	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	501,493	0.000000	0.000000	1,679	55.00
56.00	05600	RADIOISOTOPE	0	2,198,758	0.000000	0.000000	11,797	56.00
57.00	05700	CT SCAN	0	9,822,415	0.000000	0.000000	16,762	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,600,500	0.000000	0.000000	4,101	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	7,437,760	0.000000	0.000000	52,974	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,300,238	0.000000	0.000000	16,380	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	197,248	0.000000	0.000000	4,528	67.00
68.00	06800	SPEECH PATHOLOGY	0	125,250	0.000000	0.000000	827	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,588,118	0.000000	0.000000	4,954	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	26,323	0.000000	0.000000	67	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,886,413	0.000000	0.000000	69,283	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
75.01	07501	ONCOLOGY	0	700,672	0.000000	0.000000	113	75.01
75.02	07502	CARDIOPULMONARY	0	1,105,929	0.000000	0.000000	38,204	75.02
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	40,719	0.000000	0.000000	29	90.00
91.00	09100	EMERGENCY	0	8,625,686	0.000000	0.000000	2,381	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	696,093	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	55,013,521			281,330	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151312

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

Worksheet D
Part IV
Date/Time Prepared:
6/30/2014 2:17 pm

Cost Center Description		Title XIX			Hospital	Cost
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0		55.00
56.00	05600 RADIOISOTOPE	0	0	0		56.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO 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
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	07501 ONCOLOGY	0	0	0		75.01
75.02	07502 CARDIOPULMONARY	0	0	0		75.02
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: 151312	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 6/30/2014 2:17 pm
		Title XIX	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.614350	0	183,344	0	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	1.278301	0	1,030	0	0
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.428381	0	167,791	0	0
55.00 05500 RADIOLOGY-THERAPEUTIC	0.569621	0	20,475	0	0
56.00 05600 RADIOISOTOPE	0.250420	0	86,131	0	0
57.00 05700 CT SCAN	0.061075	0	414,270	0	0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.408929	0	66,378	0	0
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00 06000 LABORATORY	0.341845	0	280,631	0	0
65.00 06500 RESPIRATORY THERAPY	0.000000	0	0	0	0
66.00 06600 PHYSICAL THERAPY	0.756095	0	43,215	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.736981	0	4,879	0	0
68.00 06800 SPEECH PATHOLOGY	0.955521	0	4,779	0	0
69.00 06900 ELECTROCARDIOLOGY	0.100389	0	65,139	0	0
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.446340	0	1,092	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.391647	0	373,948	0	0
74.00 07400 RENAL DIALYSIS	0.000000	0	0	0	0
75.00 07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0
75.01 07501 ONCOLOGY	0.709330	0	30,440	0	0
75.02 07502 CARDIOPULMONARY	0.884495	0	16,834	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	5.362337	0	1,750	0	0
91.00 09100 EMERGENCY	0.462393	0	373,925	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0.764353	0	30,333	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	2,166,384	0	0
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0	0
202.00	Net Charges (line 200 +/- line 201)	0	2,166,384	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151312	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 6/30/2014 2:17 pm
		Title XIX	Hospital	Cost

Cost Center Description	Costs		Hospital	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	112,637	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,317	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	71,878	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	11,663	0	55.00
56.00	05600 RADIOISOTOPE	21,569	0	56.00
57.00	05700 CT SCAN	25,302	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	27,144	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	95,932	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	32,675	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	3,596	0	67.00
68.00	06800 SPEECH PATHOLOGY	4,566	0	68.00
69.00	06900 ELECTROCARDIOLOGY	6,539	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	487	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	146,456	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	75.00
75.01	07501 ONCOLOGY	21,592	0	75.01
75.02	07502 CARDIOPULMONARY	14,890	0	75.02
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	9,384	0	90.00
91.00	09100 EMERGENCY	172,900	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	23,185	0	92.01
OTHER REIMBURSABLE COST CENTERS				
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	98.00
200.00	Subtotal (see instructions)	803,712	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)	803,712	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151312	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 6/30/2014 2:17 pm
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,381	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,405	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)		2,405	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		885	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		91	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)		1,454	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)		885	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)		4,939,578	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)		11,752	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)		1,337,323	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,602,255	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,602,255	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)		1,497.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,177,830	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,177,830	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151312		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 6/30/2014 2:17 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	431,504	95	4,542.15	57	258,903	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							
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,057,002	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,493,735	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)					1,325,571	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)					1,325,571	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: 151312		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 6/30/2014 2:17 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151312	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 6/30/2014 2:17 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,094,864		30.00
31.00	03100 INTENSIVE CARE UNIT		68,808		31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.614350	168,333	103,415	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.278301	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.428381	76,226	32,654	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.569621	19,722	11,234	55.00
56.00	05600 RADIOISOTOPE	0.250420	150,399	37,663	56.00
57.00	05700 CT SCAN	0.061075	234,400	14,316	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.408929	54,237	22,179	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.341845	484,204	165,523	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.756095	104,145	78,744	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.736981	24,895	18,347	67.00
68.00	06800 SPEECH PATHOLOGY	0.955521	5,942	5,678	68.00
69.00	06900 ELECTROCARDIOLOGY	0.100389	62,538	6,278	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.446340	1,110	495	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.391647	515,171	201,765	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501 ONCOLOGY	0.709330	0	0	75.01
75.02	07502 CARDIOPULMONARY	0.884495	397,305	351,414	75.02
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	5.362337	485	2,601	90.00
91.00	09100 EMERGENCY	0.462393	10,156	4,696	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.764353	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)		2,309,268	1,057,002	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)		2,309,268		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151312	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3	
		Component CCN: 15Z312		Date/Time Prepared: 6/30/2014 2:17 pm	
		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
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.614350	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.278301	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.428381	14,578	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.569621	4,257	55.00
56.00	05600	RADIOISOTOPE	0.250420	21,171	56.00
57.00	05700	CT SCAN	0.061075	8,964	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.408929	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.341845	106,421	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0.756095	169,189	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.736981	54,753	67.00
68.00	06800	SPEECH PATHOLOGY	0.955521	7,719	68.00
69.00	06900	ELECTROCARDIOLOGY	0.100389	8,762	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.446340	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.391647	364,013	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	75.00
75.01	07501	ONCOLOGY	0.709330	95	75.01
75.02	07502	CARDIOPULMONARY	0.884495	182,338	75.02
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	5.362337	0	90.00
91.00	09100	EMERGENCY	0.462393	294	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.764353	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)		942,554	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)		942,554	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151312	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 6/30/2014 2:17 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		161,735		30.00
31.00	03100 INTENSIVE CARE UNIT		8,548		31.00
43.00	04300 NURSERY		11,252		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.614350	40,525	24,897	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.278301	9,530	12,182	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.428381	7,196	3,083	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.569621	1,679	956	55.00
56.00	05600 RADIOISOTOPE	0.250420	11,797	2,954	56.00
57.00	05700 CT SCAN	0.061075	16,762	1,024	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.408929	4,101	1,677	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.341845	52,974	18,109	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.756095	16,380	12,385	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.736981	4,528	3,337	67.00
68.00	06800 SPEECH PATHOLOGY	0.955521	827	790	68.00
69.00	06900 ELECTROCARDIOLOGY	0.100389	4,954	497	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.446340	67	30	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.391647	69,283	27,134	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501 ONCOLOGY	0.709330	113	80	75.01
75.02	07502 CARDIOPULMONARY	0.884495	38,204	33,791	75.02
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	5.362337	29	156	90.00
91.00	09100 EMERGENCY	0.462393	2,381	1,101	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.764353	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)		281,330	144,183	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)		281,330		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151312	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 6/30/2014 2:17 pm
		Title XVII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			7,118,830 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)			7,118,830 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)			7,190,018 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)			45,920 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			3,285,866 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)			3,858,232 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)			3,858,232 30.00
31.00	Primary payer payments			3,227 31.00
32.00	Subtotal (line 30 minus line 31)			3,855,005 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)			567,012 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			498,971 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			433,201 36.00
37.00	Subtotal (see instructions)			4,353,976 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)			4,353,976 40.00
40.01	Sequestration adjustment (see instructions)			65,745 40.01
41.00	Interim payments			5,034,176 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			-745,945 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: 151312

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

Worksheet E-1
Part I
Date/Time Prepared:
6/30/2014 2:17 pm

		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		2,001,875		4,184,976	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	01/30/2014	992,800	01/30/2014	849,200	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)		992,800		849,200	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)		2,994,675		5,034,176	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		125,552		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		745,945	6.02	
7.00	Total Medicare program liability (see instructions)		3,120,227		4,288,231	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: 151312
Component CCN: 15Z312

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

Worksheet E-1
Part I
Date/Time Prepared:
6/30/2014 2:17 pm

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		1,144,627		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	01/30/2014	537,000		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)		537,000		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,681,627		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		154,735		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,836,362		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: 151312

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

Worksheet E-1
Part II
Date/Time Prepared:
6/30/2014 2:17 pm

		Title VIII	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			959 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			1,511 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			248 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			2,500 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			58,432,979 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			3,588,954 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			15,000 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			14,244 8.00
9.00	Sequestration adjustment amount (see instructions)			285 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			13,959 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			89,869 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)			-75,910 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 151312	Period: From 01/01/2013 To 12/31/2013	Worksheet E-2
		Component CCN: 15Z312		Date/Time Prepared: 6/30/2014 2:17 pm
		Title XVIII	Swing Beds - SNF	Cost
		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)	1,338,827	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)	536,789	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	885	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)	1,875,616	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,875,616	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)	1,875,616	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	11,100	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)	1,864,516	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)	1,864,516	0	19.00
19.01	Sequestration adjustment (see instructions)	28,154	0	19.01
20.00	Interim payments	1,681,627	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	154,735	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: 151312	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part V Date/Time Prepared: 6/30/2014 2:17 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services			3,493,735 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)			3,493,735 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			3,528,672 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)			3,528,672 19.00
20.00	Deductibles (exclude professional component)			392,296 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			3,136,376 22.00
23.00	Coinsurance			592 23.00
24.00	Subtotal (line 22 minus line 23)			3,135,784 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			36,683 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			32,281 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			10,208 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			3,168,065 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)			3,168,065 30.00
30.01	Sequestration adjustment (see instructions)			47,838 30.01
31.00	Interim payments			2,994,675 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			125,552 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: 151312

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

Worksheet G

Date/Time Prepared:
6/30/2014 2:17 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	2,709,000	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	2,697,000	0	0	0	4.00
5.00	Other receivable	77,000	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	363,000	0	0	0	7.00
8.00	Prepaid expenses	95,000	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)	5,941,000	0	0	0	11.00
FIXED ASSETS						
12.00	Land	973,000	0	0	0	12.00
13.00	Land improvements	149,000	0	0	0	13.00
14.00	Accumulated depreciation	-54,000	0	0	0	14.00
15.00	Buildings	30,188,000	0	0	0	15.00
16.00	Accumulated depreciation	-1,538,000	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	1,554,000	0	0	0	19.00
20.00	Accumulated depreciation	-381,000	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	3,582,255	0	0	0	23.00
24.00	Accumulated depreciation	-1,267,833	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	333,745	0	0	0	27.00
28.00	Accumulated depreciation	-4,167	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)	33,535,000	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,057,000	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	278,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,335,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	40,811,000	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,331,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	996,000	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	131,000	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	2,994,000	0	0	0	43.00
44.00	Other current liabilities	610,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,062,000	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	23,259,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	61,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	23,320,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	29,382,000	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	11,429,000				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)	11,429,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	40,811,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151312

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

Worksheet G-1

Date/Time Prepared:
6/30/2014 2:17 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		9,757,000		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		1,669,333			2.00
3.00	Total (sum of line 1 and line 2)		11,426,333		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00	RECONCILING ITEM	2,667		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		2,667		0	10.00
11.00	Subtotal (line 3 plus line 10)		11,429,000		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		11,429,000		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	RECONCILING ITEM		0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151312

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
6/30/2014 2:17 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,216,000		2,216,000	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)	2,216,000		2,216,000	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	161,000		161,000	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)	161,000		161,000	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,377,000		2,377,000	17.00
18.00	Ancillary services	5,908,000	50,062,000	55,970,000	18.00
19.00	Outpatient services	0	569,000	569,000	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		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,285,000	50,631,000	58,916,000	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		25,566,683		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		25,566,683		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151312

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

Worksheet G-3

Date/Time Prepared:
6/30/2014 2:17 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	58,916,000	1.00
2.00	Less contractual allowances and discounts on patients' accounts	33,689,000	2.00
3.00	Net patient revenues (line 1 minus line 2)	25,227,000	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	25,566,683	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-339,683	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	39,121	6.00
7.00	Income from investments	30,803	7.00
8.00	Revenues from telephone and other miscellaneous communication services	23,237	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	3,423	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	328,717	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	18,585	16.00
17.00	Revenue from sale of drugs to other than patients	30,816	17.00
18.00	Revenue from sale of medical records and abstracts	343	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	7,627	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	541,685	22.00
23.00	Governmental appropriations	67,402	23.00
24.00	MISCELLANEOUS	917,257	24.00
25.00	Total other income (sum of lines 6-24)	2,009,016	25.00
26.00	Total (line 5 plus line 25)	1,669,333	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)	1,669,333	29.00