

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: 150172	Period: From 01/01/2013 To 12/31/2013	Worksheet S Parts I-III Date/Time Prepared: 5/29/2014 9:07 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/29/2014 Time: 9:07 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PHYSICIANS MEDICAL CENTER (150172) for the cost reporting period beginning 01/01/2013 and ending 12/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	565	53,245	-111,916	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	565	53,245	-111,916	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: 150172	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/28/2014 7:52 pm
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1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 Zip Code: 47150		4.00 County: FLOYD		1.00
1.00	Street: 4023 REES LANE	State: IN		Zip Code: 47150		County: FLOYD		2.00
2.00	City: NEW ALBANEY							

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
						V	XVIII	XIX	
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		

3.00 Hospital and Hospital-Based Component Identification:										
3.00	Hospital	PHYSICIANS MEDICAL CENTER	150172	31140	1	10/30/2008	N	P	P	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									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

						From:	To:	
						1.00	2.00	

20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2013	12/31/2013	20.00
21.00	Type of Control (see instructions)	4		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		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.	2	N	23.00

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
								1.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	25.00

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

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20	
					1.00		
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
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	
Teaching Hospitals that Claim Residents in Non-Provider Settings							
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	
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.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

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

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

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		1.00	2.00				
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y			140.00		
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:	Contractor's Number:		141.00		
142.00	Street:	PO Box:			142.00		
143.00	City:	State:	Zip Code:		143.00		
		1.00					
144.00	Are provider based physicians' costs included in Worksheet A?	Y			144.00		
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N			145.00		
		1.00	2.00				
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N			146.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N			147.00		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N			148.00		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N			149.00		
		Part A 1.00	Part B 2.00	Title V 3.00	Title XIX 4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
161.10	CORF		N	N	N	161.10	
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00	
		Name 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.				Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)				1.00	169.00	
				Beginning 1.00	Ending 2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			07/01/2013	09/30/2013	170.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150172	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/28/2014 7:52 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	A	06/30/2013	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	03/11/2014	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 150172

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

Worksheet S-2
Part II
Date/Time Prepared:
5/28/2014 7:52 pm

	Description	Part A		Part B		
		Y/N	Date	Y/N		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
						1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)						
Capital Related Cost						
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions					22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					27.00
Interest Expense						
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.					28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.00
Purchased Services						
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.					32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
Provider-Based Physicians						
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.					34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.					35.00
						1.00
						2.00
Home Office Costs						
36.00	Were home office costs claimed on the cost report?					36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
						1.00
						2.00
Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LUCIA		GERBER		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923524		LGERBER@BLUEANDCO.COM		43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	03/11/2014	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER	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: 150172

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

Worksheet S-3
Part I
Date/Time Prepared:
5/28/2014 7:52 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	12	4,380	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		12	4,380	0.00	0	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)		12	4,380	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		12				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: 150172

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

Worksheet S-3
Part I
Date/Time Prepared:
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Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	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)	60	20	214			1.00
2.00 HMO and other (see instructions)	0	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	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	60	20	214			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)	60	20	214	0.00	59.00	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	59.00	27.00
28.00 Observation Bed Days		48	540			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: 150172

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

Worksheet S-3
Part I
Date/Time Prepared:
5/28/2014 7:52 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
11.00	12.00	13.00	14.00	15.00		
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	28	9	121	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	28	9	121	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00					25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150172

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

Worksheet S-3
Part II
Date/Time Prepared:
5/28/2014 7:52 pm

	Worksheet A Line Number	Amount Reported	Reclassifi- cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	3,871,507	0	3,871,507	123,351.75	31.39
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		0	0	0	0.00	0.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		716,824	0	716,824		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		0	0	0		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FOHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00
27.00	Administrative & General	5.00	838,290	-96,389	741,901	25,512.00	29.08
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	51,340	0	51,340	1,968.00	26.09
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00
32.00	Housekeeping	9.00	31,380	0	31,380	1,874.50	16.74
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	0	0	0	0.00	0.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	0	96,389	96,389	1,961.50	49.14
39.00	Central Services and Supply	14.00	144,585	0	144,585	7,972.75	18.13
40.00	Pharmacy	15.00	0	0	0	0.00	0.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150172

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

Worksheet S-3
Part II
Date/Time Prepared:
5/28/2014 7:52 pm

		Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
42.00	Soci al Servi ce	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Servi ce	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150172

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

Worksheet S-3
Part III
Date/Time Prepared:
5/28/2014 7:52 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	3,871,507	0	3,871,507	123,351.75	31.39	1.00
2.00	Excluded area salaries (see instructions)	0	0	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	3,871,507	0	3,871,507	123,351.75	31.39	3.00
4.00	Subtotal other wages & related costs (see inst.)	0	0	0	0.00	0.00	4.00
5.00	Subtotal wage-related costs (see inst.)	716,824	0	716,824	0.00	18.52	5.00
6.00	Total (sum of lines 3 thru 5)	4,588,331	0	4,588,331	123,351.75	37.20	6.00
7.00	Total overhead cost (see instructions)	1,065,595	0	1,065,595	39,288.75	27.12	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 150172

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

Worksheet S-3
Part IV
Date/Time Prepared:
5/28/2014 7:52 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration Fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	386,055	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	27,273	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	303,497	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	716,825	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150172

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

Worksheet S-3
Part V
Date/Time Prepared:
5/28/2014 7:52 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150172	Period: From 01/01/2013 To 12/31/2013	Worksheet S-10 Date/Time Prepared: 5/28/2014 7:52 pm
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			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.202101	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		0	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		858,421	6.00
7.00	Medicaid cost (line 1 times line 6)		173,488	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)		173,488	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)		173,488	19.00
			1.00	
			2.00	
			3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	0	0	0
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	0	0	0
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	0	0	0
			1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		0	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		74,775	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		-74,775	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		-15,112	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		-15,112	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		158,376	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150172

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

Worksheet A
Date/Time Prepared:
5/28/2014 7:52 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (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 NEW CAP REL COSTS-BLDG & FIXT		1,066,250	1,066,250	281,093	1,347,343	1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP		49,634	49,634	0	49,634	2.00
3.00 00300 OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	864,395	864,395	0	864,395	4.00
5.00 00500 ADMINISTRATIVE & GENERAL	838,290	2,355,722	3,194,012	-96,389	3,097,623	5.00
7.00 00700 OPERATION OF PLANT	51,340	613,921	665,261	0	665,261	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	93,965	93,965	0	93,965	8.00
9.00 00900 HOUSEKEEPING	31,380	87,924	119,304	0	119,304	9.00
10.00 01000 DIETARY	0	34,515	34,515	0	34,515	10.00
13.00 01300 NURSING ADMINISTRATION	0	0	0	96,389	96,389	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	144,585	171,759	316,344	0	316,344	14.00
15.00 01500 PHARMACY	0	0	0	0	0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	34,037	34,037	0	34,037	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	675,012	66,291	741,303	0	741,303	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	2,046,740	19,869	2,066,609	0	2,066,609	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	84,160	0	84,160	0	84,160	54.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,485,923	1,485,923	0	1,485,923	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	1,947,067	1,947,067	0	1,947,067	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	392,639	392,639	0	392,639	73.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE		281,093	281,093	-281,093	0	113.00
118.00	3,871,507	9,565,004	13,436,511	0	13,436,511	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01 19001 SHELL SPACE	0	0	0	0	0	190.01
191.00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
200.00	3,871,507	9,565,004	13,436,511	0	13,436,511	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150172

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

Worksheet A
Date/Time Prepared:
5/28/2014 7:52 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-55,783	1,291,560	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-10,125	39,509	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	864,395	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-983,840	2,113,783	5.00
7.00	00700	OPERATION OF PLANT	0	665,261	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	93,965	8.00
9.00	00900	HOUSEKEEPING	0	119,304	9.00
10.00	01000	DIETARY	0	34,515	10.00
13.00	01300	NURSING ADMINISTRATION	0	96,389	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	316,344	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	34,037	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-62,600	678,703	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,066,609	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	84,160	54.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,485,923	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,947,067	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	392,639	73.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,112,348	12,324,163	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	SHELLED SPACE	0	0	190.01
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		TOTAL (SUM OF LINES 118-199)	-1,112,348	12,324,163	200.00

Provider CCN: 150172

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

Worksheet A-6
Date/Time Prepared:
5/28/2014 7:52 pm

		Increases			
Cost Center		Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - INTEREST					
1.00	NEW CAP REL COSTS-BLDG & FI XT	1.00	0	281,093	1.00
	TOTALS		0	281,093	
B - NURSING ADMIN SALARY					
1.00	NURSING ADMINISTRATION	13.00	96,389	0	1.00
	TOTALS		96,389	0	
500.00	Grand Total: Increases		96,389	281,093	500.00

Provider CCN: 150172

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

Worksheet A-6
Date/Time Prepared:
5/28/2014 7:52 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	281,093	11	1.00
	TOTALS		0	281,093		
B - NURSING ADMIN SALARY						
1.00	ADMINISTRATIVE & GENERAL	5.00	96,389	0	0	1.00
	TOTALS		96,389	0		
500.00	Grand Total: Decreases		96,389	281,093		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150172

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

Worksheet A-7
Part I
Date/Time Prepared:
5/28/2014 7:52 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	999,549	0	0	0	1.00
2.00	Land Improvements	768,718	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	7,403,347	36,004	0	36,004	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	4,322,599	543,654	0	543,654	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	13,494,213	579,658	0	579,658	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	13,494,213	579,658	0	579,658	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	999,549	0			1.00
2.00	Land Improvements	768,718	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	7,439,351	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	4,866,253	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	14,073,871	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	14,073,871	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150172

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

Worksheet A-7
Part II
Date/Time Prepared:
5/28/2014 7:52 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	927,662	0	0	0	138,588	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	7,711	41,923	0	0	0	2.00
3.00	Total (sum of lines 1-2)	935,373	41,923	0	0	138,588	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,066,250				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	49,634				2.00
3.00	Total (sum of lines 1-2)	0	1,115,884				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150172

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

Worksheet A-7
Part III
Date/Time Prepared:
5/28/2014 7:52 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	9,207,617	0	9,207,617	0.654235	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4,866,254	0	4,866,254	0.345765	0	2.00
3.00	Total (sum of lines 1-2)	14,073,871	0	14,073,871	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	927,662	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	7,711	41,923	2.00
3.00	Total (sum of lines 1-2)	0	0	0	935,373	41,923	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	NEW CAP REL COSTS-BLDG & FIXT	225,310	0	138,588	0	1,291,560	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-10,125	0	0	0	39,509	2.00
3.00	Total (sum of lines 1-2)	215,185	0	138,588	0	1,331,069	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150172

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

Worksheet A-8

Date/Time Prepared:
5/28/2014 7:52 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		
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-55,783	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-62,600			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests		0		0.00	0	14.00
15.00 Rental of quarters to employee and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts		0		0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

Provider CCN: 150172

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

Worksheet A-8

Date/Time Prepared:
 5/28/2014 7:52 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
33.00	REMOVAL OF SUITE LEASE	A	-907,410	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00			0		0.00	0	34.00
35.00			0		0.00	0	35.00
36.00	MARKETING COSTS	A	-76,358	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	GAIN/LOSS INT RATE SWAP	A	-5,578	NEW CAP REL COSTS-MVBLE	2.00	11	37.00
38.00	GAIN ON INT RATE SWAP	A	-4,547	EQUIP			
				NEW CAP REL COSTS-MVBLE	2.00	11	38.00
39.00	OTHER INCOME	A	-72	EQUIP			
				ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00			0		0.00	0	40.00
41.00			0		0.00	0	41.00
42.00			0		0.00	0	42.00
43.00			0		0.00	0	43.00
44.00			0		0.00	0	44.00
45.00			0		0.00	0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,112,348				50.00

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

Provider CCN: 150172

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

Worksheet A-8-1

Date/Time Prepared:
5/28/2014 7:52 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	5.00	ADMINISTRATIVE & GENERAL	1	1	1.00
2.00	0.00		0	0	2.00
3.00	0.00		0	0	3.00
4.00	0.00		0	0	4.00
5.00	0	0	1	1	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	C	VARIOUS PHYSICI	100.00	PHYS MED CTR	0.00	6.00
7.00	A	VARIOUS PHYSICI	100.00	PHYS SURG PROP	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: 150172

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

Worksheet A-8-1

Date/Time Prepared:
5/28/2014 7:52 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	0	0	1.00
2.00	0	0	2.00
3.00	0	0	3.00
4.00	0	0	4.00
5.00	0	0	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	HOSPITAL	6.00
7.00	PROPERTY CO	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: 150172

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

Worksheet A-8-2

Date/Time Prepared:
5/28/2014 7:52 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	62,600	62,600	0	159,800	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			62,600	62,600	0	0	0	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	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	62,600		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	62,600		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150172

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

Worksheet B
Part I
Date/Time Prepared:
5/28/2014 7:52 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	1,291,560	1,291,560			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	39,509		39,509		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	864,395	0	0	864,395	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,113,783	221,384	6,772	165,645	2,507,584 5.00
7.00 00700	OPERATION OF PLANT	665,261	82,194	2,514	11,463	761,432 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	93,965	0	0	0	93,965 8.00
9.00 00900	HOUSEKEEPING	119,304	18,265	559	7,006	145,134 9.00
10.00 01000	DIETARY	34,515	19,872	608	0	54,995 10.00
13.00 01300	NURSING ADMINISTRATION	96,389	0	0	21,521	117,910 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	316,344	205,740	6,294	32,282	560,660 14.00
15.00 01500	PHARMACY	0	5,031	154	0	5,185 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	34,037	20,210	618	0	54,865 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	678,703	334,105	10,220	150,711	1,173,739 30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	2,066,609	378,755	11,586	456,977	2,913,927 50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	84,160	6,004	184	18,790	109,138 54.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,485,923	0	0	0	1,485,923 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	1,947,067	0	0	0	1,947,067 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	392,639	0	0	0	392,639 73.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0 99.10
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	12,324,163	1,291,560	39,509	864,395	12,324,163 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
190.01 19001	SHELLED SPACE	0	0	0	0	0 190.01
191.00 19100	RESEARCH	0	0	0	0	0 191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
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					0 201.00
202.00	TOTAL (sum lines 118-201)	12,324,163	1,291,560	39,509	864,395	12,324,163 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150172

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

Worksheet B
Part I
Date/Time Prepared:
5/28/2014 7:52 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,507,584				5.00
7.00	00700	OPERATION OF PLANT	194,503	955,935			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	24,003	0	117,968		8.00
9.00	00900	HOUSEKEEPING	37,074	17,673	0	199,881	9.00
10.00	01000	DIETARY	14,048	19,228	0	4,096	92,367
13.00	01300	NURSING ADMINISTRATION	30,119	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	143,217	199,066	0	42,408	14.00
15.00	01500	PHARMACY	1,324	4,868	0	1,037	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,015	19,555	0	4,166	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	299,825	323,268	5,898	68,867	92,367
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	744,343	366,468	112,070	78,069	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,879	5,809	0	1,238	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	379,570	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	497,367	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	100,297	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,507,584	955,935	117,968	199,881	92,367
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
190.01	19001	SHELLED SPACE	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	2,507,584	955,935	117,968	199,881	92,367

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150172

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

Worksheet B
Part I
Date/Time Prepared:
5/28/2014 7:52 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
13.00	01300	148,029					13.00
14.00	01400	0	945,351				14.00
15.00	01500	0	0	12,414			15.00
16.00	01600	0	0	0	92,601		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	18,549	0	0	228	1,982,741	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	129,480	0	0	57,088	4,401,445	50.00
54.00	05400	0	0	0	9,692	153,756	54.00
71.00	07100	0	406,501	0	14,585	2,286,579	71.00
72.00	07200	0	538,850	0	6,081	2,989,365	72.00
73.00	07300	0	0	12,414	4,927	510,277	73.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		148,029	945,351	12,414	92,601	12,324,163	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	0	0	0	0	0	190.01
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
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		148,029	945,351	12,414	92,601	12,324,163	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150172

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

Worksheet B
Part I
Date/Time Prepared:
5/28/2014 7:52 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,982,741
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	4,401,445
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	153,756
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,286,579
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,989,365
73.00	07300	DRUGS CHARGED TO PATIENTS	0	510,277
OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	12,324,163
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0
190.01	19001	SHELLED SPACE	0	0
191.00	19100	RESEARCH	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0
193.00	19300	NONPAID WORKERS	0	0
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	12,324,163

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150172

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

Worksheet B
Part II
Date/Time Prepared:
5/28/2014 7:52 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	221,384	6,772	228,156	5.00
7.00 00700	OPERATION OF PLANT	0	82,194	2,514	84,708	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	18,265	559	18,824	9.00
10.00 01000	DIETARY	0	19,872	608	20,480	10.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	205,740	6,294	212,034	14.00
15.00 01500	PHARMACY	0	5,031	154	5,185	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	20,210	618	20,828	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	334,105	10,220	344,325	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	378,755	11,586	390,341	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	6,004	184	6,188	54.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,291,560	39,509	1,331,069	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.01 19001	SHELLED SPACE	0	0	0	0	190.01
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,291,560	39,509	1,331,069	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150172		Period: From 01/01/2013 To 12/31/2013		Worksheet B Part II Date/Time Prepared: 5/28/2014 7:52 pm	
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	228,156				5.00
7.00	00700	OPERATION OF PLANT	17,697	102,405			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,184	0	2,184		8.00
9.00	00900	HOUSEKEEPING	3,373	1,893	0	24,090	9.00
10.00	01000	DIETARY	1,278	2,060	0	494	24,312
13.00	01300	NURSING ADMINISTRATION	2,740	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,031	21,325	0	5,111	14.00
15.00	01500	PHARMACY	121	522	0	125	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,275	2,095	0	502	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	27,280	34,630	109	8,300	24,312
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	67,724	39,258	2,075	9,409	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,537	622	0	149	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	34,536	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	45,254	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	9,126	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	228,156	102,405	2,184	24,090	24,312
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
190.01	19001	SHELLED SPACE	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	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	0
202.00		TOTAL (sum lines 118-201)	228,156	102,405	2,184	24,090	24,312

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150172

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

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Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
13.00	01300	2,740					13.00
14.00	01400	0	251,501				14.00
15.00	01500	0	0	5,953			15.00
16.00	01600	0	0	0	24,700		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	343	0	0	61	439,360	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,397	0	0	15,231	526,435	50.00
54.00	05400	0	0	0	2,584	12,080	54.00
71.00	07100	0	108,145	0	3,889	146,570	71.00
72.00	07200	0	143,356	0	1,621	190,231	72.00
73.00	07300	0	0	5,953	1,314	16,393	73.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		2,740	251,501	5,953	24,700	1,331,069	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	0	0	0	0	0	190.01
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
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		2,740	251,501	5,953	24,700	1,331,069	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150172

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	439,360
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	526,435
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,080
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	146,570
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	190,231
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,393
OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,331,069
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0
190.01	19001	SHELLED SPACE	0	0
191.00	19100	RESEARCH	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0
193.00	19300	NONPAID WORKERS	0	0
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	1,331,069

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150172

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

Worksheet B-1
Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCU. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	30,547				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		30,547			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	3,871,507		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	5,236	5,236	741,901	-2,507,584	9,816,579
7.00 00700	OPERATION OF PLANT	1,944	1,944	51,340	0	761,432
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	93,965
9.00 00900	HOUSEKEEPING	432	432	31,380	0	145,134
10.00 01000	DIETARY	470	470	0	0	54,995
13.00 01300	NURSING ADMINISTRATION	0	0	96,389	0	117,910
14.00 01400	CENTRAL SERVICES & SUPPLY	4,866	4,866	144,585	0	560,660
15.00 01500	PHARMACY	119	119	0	0	5,185
16.00 01600	MEDICAL RECORDS & LIBRARY	478	478	0	0	54,865
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	7,902	7,902	675,012	0	1,173,739
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	8,958	8,958	2,046,740	0	2,913,927
54.00 05400	RADIOLOGY-DIAGNOSTIC	142	142	84,160	0	109,138
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,485,923
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,947,067
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	392,639
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	30,547	30,547	3,871,507	-2,507,584	9,816,579
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
190.01 19001	SHELLED SPACE	0	0	0	0	0
191.00 19100	RESEARCH	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	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)	1,291,560	39,509	864,395		2,507,584
203.00	Unit cost multiplier (Wkst. B, Part I)	42.281075	1.293384	0.223271		0.255444
204.00	Cost to be allocated (per Wkst. B, Part II)			0		228,156
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.023242

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150172

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	NURSING ADMINISTRATION (NURSING HOURS)	
		7.00	8.00	9.00	10.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	23,367				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	100			8.00
9.00	00900	HOUSEKEEPING	432	0	22,935		9.00
10.00	01000	DIETARY	470	0	470	100	10.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	76,763	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,866	0	4,866	0	14.00
15.00	01500	PHARMACY	119	0	119	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	478	0	478	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,902	5	7,902	100	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,958	95	8,958	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	142	0	142	0	54.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,367	100	22,935	100	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.01	19001	SHELLED SPACE	0	0	0	0	190.01
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
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		Cost to be allocated (per Wkst. B, Part I)	955,935	117,968	199,881	92,367	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	40.909616	1,179.680000	8.715108	923.670000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	102,405	2,184	24,090	24,312	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.382462	21.840000	1.050360	243.120000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150172

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

Worksheet B-1
Date/Time Prepared:
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Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUISITIO)	MEDICAL RECORDS & LIBRARY (PATIENT REVENUE)	
		14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
13.00	01300				13.00
14.00	01400	100			14.00
15.00	01500	0	100		15.00
16.00	01600	0	0	45,310,159	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	0	0	111,713	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	0	0	27,935,946	50.00
54.00	05400	0	0	4,741,817	54.00
71.00	07100	43	0	7,135,466	71.00
72.00	07200	57	0	2,974,977	72.00
73.00	07300	0	100	2,410,240	73.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200				92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		100	100	45,310,159	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	0	0	0	190.00
190.01	19001	0	0	0	190.01
191.00	19100	0	0	0	191.00
192.00	19200	0	0	0	192.00
193.00	19300	0	0	0	193.00
200.00					200.00
201.00					201.00
202.00		945,351	12,414	92,601	202.00
203.00		9,453.510000	124.140000	0.002044	203.00
204.00		251,501	5,953	24,700	204.00
205.00		2,515.010000	59.530000	0.000545	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150172

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

Worksheet C
Part I
Date/Time Prepared:
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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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	1,982,741		1,982,741	0	1,982,741 30.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	4,401,445		4,401,445	0	4,401,445 50.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	153,756		153,756	0	153,756 54.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,286,579		2,286,579	0	2,286,579 71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	2,989,365		2,989,365	0	2,989,365 72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	510,277		510,277	0	510,277 73.00	
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,420,000		1,420,000		1,420,000 92.00	
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0		0		0 99.10	
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						
200.00	Subtotal (see instructions)	13,744,163	0	13,744,163	0	13,744,163 200.00	
201.00	Less Observation Beds	1,420,000		1,420,000		1,420,000 201.00	
202.00	Total (see instructions)	12,324,163	0	12,324,163	0	12,324,163 202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150172

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

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	111,713		111,713			30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,620,726	26,315,220	27,935,946	0.157555	0.000000	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	34,967	4,706,850	4,741,817	0.032426	0.000000	54.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	424,271	6,711,195	7,135,466	0.320453	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	649,329	2,325,648	2,974,977	1.004836	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	122,790	2,287,450	2,410,240	0.211712	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	15,670,112	15,670,112	0.090618	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0	0	0			99.10
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	2,963,796	58,016,475	60,980,271			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	2,963,796	58,016,475	60,980,271			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150172	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/28/2014 7:52 pm
		Title XVIII	Hospital	PPS
Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.157555		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.032426		54.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.320453		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1.004836		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.211712		73.00
OUTPATIENT SERVICE COST CENTERS				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.090618		92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910 CORF			99.10
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150172

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

Worksheet C
Part I
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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	1,982,741		1,982,741	0	1,982,741 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	4,401,445		4,401,445	0	4,401,445 50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	153,756		153,756	0	153,756 54.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,286,579		2,286,579	0	2,286,579 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	2,989,365		2,989,365	0	2,989,365 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	510,277		510,277	0	510,277 73.00
OUTPATIENT SERVICE COST CENTERS						
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,420,000		1,420,000		1,420,000 92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910 CORF	0		0		0 99.10
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					
200.00	Subtotal (see instructions)	13,744,163	0	13,744,163	0	13,744,163 200.00
201.00	Less Observation Beds	1,420,000		1,420,000		1,420,000 201.00
202.00	Total (see instructions)	12,324,163	0	12,324,163	0	12,324,163 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150172

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

Worksheet C
Part I
Date/Time Prepared:
5/28/2014 7:52 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XIX Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	111,713		111,713		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,620,726	26,315,220	27,935,946	0.157555	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,967	4,706,850	4,741,817	0.032426	54.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	424,271	6,711,195	7,135,466	0.320453	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	649,329	2,325,648	2,974,977	1.004836	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	122,790	2,287,450	2,410,240	0.211712	73.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	15,670,112	15,670,112	0.090618	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	2,963,796	58,016,475	60,980,271		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	2,963,796	58,016,475	60,980,271		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150172

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

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	PPS
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.157555			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.032426			54.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.320453			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1.004836			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.211712			73.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.090618			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910 CORF				99.10
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

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

Provider CCN: 150172

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

Worksheet C Part II Date/Time Prepared: 5/28/2014 7:52 pm

Cost Center Description		Title XIX					Hospital	PPS
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,401,445	526,435	3,875,010	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	153,756	12,080	141,676	0	0	54.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,286,579	146,570	2,140,009	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,989,365	190,231	2,799,134	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	510,277	16,393	493,884	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,420,000	314,661	1,105,339	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	11,761,422	1,206,370	10,555,052	0	0	200.00
201.00		Less Observation Beds	1,420,000	314,661	1,105,339	0	0	201.00
202.00		Total (line 200 minus line 201)	10,341,422	891,709	9,449,713	0	0	202.00

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

Provider CCN: 150172

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

Worksheet C Part II Date/Time Prepared: 5/28/2014 7:52 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
		6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	4,401,445	27,935,946	0.157555	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	153,756	4,741,817	0.032426	54.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,286,579	7,135,466	0.320453	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	2,989,365	2,974,977	1.004836	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	510,277	2,410,240	0.211712	73.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,420,000	15,670,112	0.090618	92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910 CORF	0	0	0.000000	99.10
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (sum of lines 50 thru 199)	11,761,422	60,868,558		200.00
201.00	Less Observation Beds	1,420,000	0		201.00
202.00	Total (line 200 minus line 201)	10,341,422	60,868,558		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150172		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part I Date/Time Prepared: 5/28/2014 7:52 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	439,360	0	439,360	754	582.71	
200.00	Total (Lines 30-199)	439,360		439,360	754	200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	60	34,963	30.00			
200.00	Total (Lines 30-199)	60	34,963	200.00			

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 150172	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/28/2014 7:52 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	526,435	27,935,946	0.018844	357,793	6,742	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	12,080	4,741,817	0.002548	7,498	19	54.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	146,570	7,135,466	0.020541	107,019	2,198	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	190,231	2,974,977	0.063944	165,237	10,566	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	16,393	2,410,240	0.006801	34,782	237	73.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	314,661	15,670,112	0.020080	0	0	92.00
200.00	Total (lines 50-199)	1,206,370	60,868,558		672,329	19,762	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150172		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part III Date/Time Prepared: 5/28/2014 7:52 pm	
Title XVIII			Hospital			PPS		
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	
200.00		Total (lines 30-199)	0	0	0	0	0	
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	754	0.00	60	0	30.00	
200.00		Total (lines 30-199)	754		60	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150172

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

Worksheet D
Part IV
Date/Time Prepared:
5/28/2014 7:52 pm

Cost Center Description		Title XVIII			Hospital		PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150172	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/28/2014 7:52 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	27,935,946	0.000000	0.000000	357,793	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	4,741,817	0.000000	0.000000	7,498	54.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,135,466	0.000000	0.000000	107,019	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	2,974,977	0.000000	0.000000	165,237	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2,410,240	0.000000	0.000000	34,782	73.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	15,670,112	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	60,868,558			672,329	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150172

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

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XVIII Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	7,972,847	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	364,147	0	54.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,249,799	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	799,857	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	731,766	0	73.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	5,046,392	0	92.00
200.00	Total (lines 50-199)	0	17,164,808	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150172

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

Worksheet D
Part V
Date/Time Prepared:
5/28/2014 7:52 pm

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.157555	7,972,847	0	0	1,256,162	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.032426	364,147	0	0	11,808	54.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.320453	2,249,799	0	0	720,955	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.004836	799,857	0	0	803,725	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211712	731,766	0	0	154,924	73.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.090618	5,046,392	0	0	457,294	92.00
200.00		Subtotal (see instructions)		17,164,808	0	0	3,404,868	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		17,164,808	0	0	3,404,868	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150172	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/28/2014 7:52 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Subtotal (see instructions)	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150172		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part I Date/Time Prepared: 5/28/2014 7:52 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	439,360	0	439,360	754	582.71	
200.00	Total (Lines 30-199)	439,360		439,360	754	200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	20	11,654	30.00			
200.00	Total (Lines 30-199)	20	11,654	200.00			

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 150172	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/28/2014 7:52 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital 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	526,435	27,935,946	0.018844	142,325	2,682	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	12,080	4,741,817	0.002548	1,603	4	54.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	146,570	7,135,466	0.020541	25,555	525	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	190,231	2,974,977	0.063944	63,087	4,034	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	16,393	2,410,240	0.006801	4,319	29	73.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	314,661	15,670,112	0.020080	0	0	92.00
200.00	Total (lines 50-199)	1,206,370	60,868,558		236,889	7,274	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150172		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part III Date/Time Prepared: 5/28/2014 7:52 pm	
Cost Center Description			Title XIX		Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	
200.00		Total (lines 30-199)	0	0	0	0	0	
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	754	0.00	20	0	30.00	
200.00		Total (lines 30-199)	754		20	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150172

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

Worksheet D
Part IV
Date/Time Prepared:
5/28/2014 7:52 pm

Cost Center Description		Title XIX			Hospital		PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150172

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

Worksheet D
Part IV
Date/Time Prepared:
5/28/2014 7:52 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	27,935,946	0.000000	0.000000	142,325	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	4,741,817	0.000000	0.000000	1,603	54.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,135,466	0.000000	0.000000	25,555	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	2,974,977	0.000000	0.000000	63,087	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2,410,240	0.000000	0.000000	4,319	73.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	15,670,112	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	60,868,558			236,889	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150172

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

Worksheet D
Part IV
Date/Time Prepared:
5/28/2014 7:52 pm

Cost Center Description		Title XIX			Hospital	PPS
		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
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS						
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00	Total (Lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150172

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

Worksheet D
Part V
Date/Time Prepared:
5/28/2014 7:52 pm

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.157555	0	0	1,767,899	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.032426	0	0	30,945	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.320453	0	0	347,173	0
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1.004836	0	0	137,239	0
73.00	07300 DRUGS CHARGED TO PATIENTS	0.211712	0	0	104,432	0
OUTPATIENT SERVICE COST CENTERS						
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.090618	0	0	544,278	0
200.00	Subtotal (see instructions)		0	0	2,931,966	0
201.00	Less PBP Clinic Lab. Services-Program Only Charges				0	
202.00	Net Charges (line 200 +/- line 201)		0	0	2,931,966	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150172	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/28/2014 7:52 pm
	Title XIX	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	278,541	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	1,003	54.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	111,253	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	137,903	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	22,110	73.00
OUTPATIENT SERVICE COST CENTERS				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	49,321	92.00
200.00	Subtotal (see instructions)	0	600,131	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	600,131	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150172	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/28/2014 7:52 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		754	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		754	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)		214	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		60	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,982,741	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,982,741	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)		1,982,741	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)		2,629.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		157,778	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)		157,778	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150172		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 5/28/2014 7:52 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)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					264,310	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					422,088	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)					34,963	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					19,762	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					54,725	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					367,363	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					540	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,629.63	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,420,000	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150172		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/28/2014 7:52 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	439,360	1,982,741	0.221592	1,420,000	314,661	90.00
91.00	Nursing School cost	0	1,982,741	0.000000	1,420,000	0	91.00
92.00	Allied health cost	0	1,982,741	0.000000	1,420,000	0	92.00
93.00	All other Medical Education	0	1,982,741	0.000000	1,420,000	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150172	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/28/2014 7:52 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		754	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		754	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)		214	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		20	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,982,741	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,982,741	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)		1,982,741	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)		2,629.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		52,593	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)		52,593	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150172		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
Title XIX		Hospital		PPS			
1.00		2.00		3.00		4.00	
5.00							
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					94,971	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					147,564	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)					11,654	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					7,274	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					18,928	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					128,636	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					540	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,629.63	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,420,000	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150172		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/28/2014 7:52 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	439,360	1,982,741	0.221592	1,420,000	314,661	90.00
91.00	Nursing School cost	0	1,982,741	0.000000	1,420,000	0	91.00
92.00	Allied health cost	0	1,982,741	0.000000	1,420,000	0	92.00
93.00	All other Medical Education	0	1,982,741	0.000000	1,420,000	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150172	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/28/2014 7:52 pm	
Cost Center Description		Title XVIII	Hospital	PPS	
		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		35,820		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.157555	357,793	56,372	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.032426	7,498	243	54.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.320453	107,019	34,295	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1.004836	165,237	166,036	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.211712	34,782	7,364	73.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.090618	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		672,329	264,310	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)		672,329		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150172	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/28/2014 7:52 pm	
Cost Center Description		Title XIX	Hospital	PPS	
		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		16,415		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.157555	142,325	22,424	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.032426	1,603	52	54.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.320453	25,555	8,189	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1.004836	63,087	63,392	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.211712	4,319	914	73.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.090618	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		236,889	94,971	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)		236,889		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150172	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/28/2014 7:52 pm
		Title XVIII	Hospital	PPS
		0	1.00	2.00
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013 (see instructions)		208,942	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		27,790	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI (see instructions)		0	1.03
2.00	Outlier payments for discharges. (see instructions)		0	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		10.52	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		0.00	30.00
31.00	Percentage of Medicaid patient days (see instructions)		0.00	31.00
32.00	Sum of lines 30 and 31		0.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00	33.00
34.00	Disproportionate share adjustment (see instructions)		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150172	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/28/2014 7:52 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1	On/After October 1	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)			0	35.00
35.01	Factor 3 (see instructions)			0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)			0	36.00
Additional payment for high percentage of ESRD beneficiary discharges					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)			0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)			0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)			0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41)			0	46.00
47.00	Subtotal (see instructions)		236,732		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)			0	48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		236,732		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		18,639		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)			0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)			0	56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).			0	57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		255,371		59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		255,371		61.00
62.00	Deductibles billed to program beneficiaries			30,756	62.00
63.00	Coinurance billed to program beneficiaries			0	63.00
64.00	Allowable bad debts (see instructions)			2,537	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			1,649	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			2,537	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			226,264	67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)			0	68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.92	Bundled Model 1 discount amount			0	70.92
70.93	HVBP incentive payment (see instructions)			-235	70.93
70.94	Hospital readmissions reduction adjustment (see instructions)			0	70.94
70.95	Recovery of Accelerated Depreciation			0	70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150172	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/28/2014 7:52 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	On/After October 1 2.00	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		226,029		71.00
71.01	Sequestration adjustment (see instructions)		3,413		71.01
72.00	Interim payments		222,051		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) line 71 minus lines 71.01, 72 and 73		565		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0		75.00
TO BE COMPLETED BY CONTRACTOR					
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the Time Value of Money		0.00		94.00
95.00	Time Value of Money for operating expenses(see instructions)		0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)		0		96.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150172

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/28/2014 7:52 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013	1.01	208,942	0	208,942	0	208,942	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013	1.02	27,790	0	0	27,790	27,790	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI	1.03	0	0	0	0	0	1.03
2.00	Outlier payments for discharges (see instructions)	2.00	0	0	0	0	0	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	Amount from Worksheet E Part A, line 27 (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	0	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	236,732	0	208,942	27,790	236,732	13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49.00	236,732	0	208,942	27,790	236,732	15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50.00	18,639	0	16,441	2,198	18,639	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	225,383	29,988	255,371	19.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150172

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/28/2014 7:52 pm

		Title XVIII		Hospital		PPS		
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	18,639	0	16,441	2,198	18,639	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (line 20 times line 22)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (line 20 times line 24)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	12.00	18,639	0	16,441	2,198	18,639	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.250000	0.250000		27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.96			56,346		56,346	28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.97				7,497	7,497	29.00
100.00	Transfer low volume adjustments to W/S E Part A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150172	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/28/2014 7:52 pm
		Title XVII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		3,404,868	2.00
3.00	PPS payments		5,557,752	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)		0	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)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		5,557,752	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,105,903	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		4,451,849	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		4,451,849	30.00
31.00	Primary payer payments		8,355	31.00
32.00	Subtotal (line 30 minus line 31)		4,443,494	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)		112,501	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		73,126	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		112,501	36.00
37.00	Subtotal (see instructions)		4,516,620	37.00
38.00	MSP-LCC reconciliation amount from PS&R		2,073	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)		4,514,547	40.00
40.01	Sequestration adjustment (see instructions)		68,170	40.01
41.00	Interim payments		4,393,132	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		53,245	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: 150172

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

Worksheet E-1
Part I
Date/Time Prepared:
5/28/2014 7:52 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		222,051		4,393,132	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		222,051		4,393,132	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		565		53,245	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		222,616		4,446,377	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: 150172

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

Worksheet E-1
Part II
Date/Time Prepared:
5/28/2014 7:52 pm

Title XVIII		Hospital	PPS
			1.00

TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS			
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	121	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	60	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2	0	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	214	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	60,980,271	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	0	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	560,800	8.00
9.00	Sequestration adjustment amount (see instructions)	11,216	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	549,584	10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30.00	Initial/interim HIT payment adjustment (see instructions)	661,500	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)	-111,916	32.00

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

Provider CCN: 150172

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

Worksheet G

Date/Time Prepared:
5/28/2014 7:52 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	146,750	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	11,227,508	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,500,221	0	0	0	6.00
7.00	Inventory	576,191	0	0	0	7.00
8.00	Prepaid expenses	85,394	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	1,480,125	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,015,747	0	0	0	11.00
FIXED ASSETS						
12.00	Land	999,549	0	0	0	12.00
13.00	Land improvements	768,718	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	7,439,350	0	0	0	17.00
18.00	Accumulated depreciation	-1,344,347	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	3,563,693	0	0	0	23.00
24.00	Accumulated depreciation	-2,349,817	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	1,311,861	0	0	0	27.00
28.00	Accumulated depreciation	-1,102,188	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)	9,286,819	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	6,700,131	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,700,131	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	22,002,697	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,313,969	0	0	0	37.00
38.00	Salaries, wages, and fees payable	252,982	0	0	0	38.00
39.00	Payroll taxes payable	7,411	0	0	0	39.00
40.00	Notes and loans payable (short term)	6,292,777	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	1,480,125	0	0	0	43.00
44.00	Other current liabilities	678,752	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	10,026,016	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	10,026,016	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	11,976,681				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)	11,976,681	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	22,002,697	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150172

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

Worksheet G-1

Date/Time Prepared:
5/28/2014 7:52 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		7,077,706			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		4,898,975				2.00
3.00	Total (sum of line 1 and line 2)		11,976,681			0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0			0	10.00
11.00	Subtotal (line 3 plus line 10)		11,976,681			0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		11,976,681			0	19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150172

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/28/2014 7:52 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	358,079		358,079	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)	358,079		358,079	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	358,079		358,079	17.00
18.00	Ancillary services	8,182,865	52,203,797	60,386,662	18.00
19.00	Outpatient services	0	235,529	235,529	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,540,944	52,439,326	60,980,270	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		13,436,511		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)		13,436,511		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150172

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

Worksheet G-3

Date/Time Prepared:
5/28/2014 7:52 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	60,980,270	1.00
2.00	Less contractual allowances and discounts on patients' accounts	43,618,174	2.00
3.00	Net patient revenues (line 1 minus line 2)	17,362,096	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	13,436,511	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,925,585	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	65,908	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	907,410	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	72	24.00
25.00	Total other income (sum of lines 6-24)	973,390	25.00
26.00	Total (line 5 plus line 25)	4,898,975	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)	4,898,975	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150172	Period: From 01/01/2013 To 12/31/2013	Worksheet L Parts I-III Date/Time Prepared: 5/28/2014 7:52 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		18,639	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		0.59	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		0	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		18,639	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00