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: 140013	Period: From 01/01/2013 To 12/31/2013	Worksheet S Parts I-III Date/Time Prepared: 5/22/2014 7:59 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/22/2014 Time: 7:59 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] 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 PROCTOR HOSPITAL (140013) 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	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	85,246	154,958	136,380	0	1.00
2.00	Subprovider - IPF	0	2,331	18		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
7.00	SKILLED NURSING FACILITY	0	460	2		0	7.00
9.00	HOME HEALTH AGENCY I	0	-1	0		0	9.00
200.00	Total	0	88,036	154,978	136,380	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: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 5/22/2014 7:57 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 5409 N. KNOXVILLE	PO Box:			1.00
2.00	City: PEORIA	State: IL	Zip Code: 61614	County: PEORIA	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	PROCTOR HOSPITAL	140013	37900	1	08/01/1996	N	P	P	3.00
4.00	Subprovider - IPF	PROCTOR HOSPITAL	14S013	37900	4	11/30/2012	N	P	P	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	PROCTOR HOSPITAL	145579	37900		11/03/1987	N	P	P	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	PROCTOR HOSPITAL	147049	37900		09/01/1997	N	P	P	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2013	12/31/2013	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)			22.01
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,103	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		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 5/22/2014 7:57 pm

		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)			39.00

		V	XVIII	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	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	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	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		Program Name	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 5/22/2014 7:57 pm

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	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 Nonprovider Site	Unweighted FTEs in Hospital	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	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	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I | Date/Time Prepared: 5/22/2014 7:57 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	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.	Y			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N		0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 5/22/2014 7:57 pm

		V	XIX	
		1.00	2.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,449,275	0	0	118.01

		V	XIX	
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I | Date/Time Prepared: 5/22/2014 7:57 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	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	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00

		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	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	1.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	04/02/2013	06/30/2013	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part II | Date/Time Prepared: 5/22/2014 7:57 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	05/02/2013	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part II Date/Time Prepared: 5/22/2014 7:57 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
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 relifed 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
			Y/N	Date		
			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.	DANIEL	LINHART			41.00
42.00	Enter the employer/company name of the cost report preparer.	MCGLADREY				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-888-4404	DAN.LINHART@MCGLADREY.COM			43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part II Date/Time Prepared: 5/22/2014 7:57 pm

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	05/02/2013			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: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part I Date/Time Prepared: 5/22/2014 7:57 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	130	47,450	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)		130	47,450	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	12	4,380	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		142	51,830	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	12	4,380		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	20	7,300		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		174				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: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part I | Date/Time Prepared: 5/22/2014 7:57 pm

	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)	11,261	868	19,634			1.00
2.00	HMO and other (see instructions)	2,801	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)	11,261	868	19,634			7.00
8.00	INTENSIVE CARE UNIT	1,317	99	2,073			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		262	1,127			13.00
14.00	Total (see instructions)	12,578	1,229	22,834	0.00	727.97	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,495	9	3,059	0.00	18.08	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	3,096	0	4,530	0.00	20.93	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	3,049	0	5,289	0.00	6.46	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	773.44	27.00
28.00	Observation Bed Days		0	2,734			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			105			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: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part I Date/Time Prepared: 5/22/2014 7:57 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		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	2,566	493	5,419	1.00
2.00	HMO and other (see instructions)			648			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	2,566	493	5,419	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	210	1	278	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part II Date/Time Prepared: 5/22/2014 7:57 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	37,502,894	0	37,502,894	1,586,880.00	23.63	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	1,058,063	49,082	1,107,145	46,928.00	23.59	9.00
10.00	Excluded area salaries (see instructions)		3,184,970	217,227	3,402,197	163,599.00	20.80	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		1,413,660	0	1,413,660	33,396.00	42.33	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		74,124	0	74,124	1,040.00	71.27	13.00
14.00	Home office salaries & wage-related costs		234,982	0	234,982	2,375.00	98.94	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		10,844,393	0	10,844,393			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,477,444	0	1,477,444			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	75,888	0	75,888	2,031.00	37.36	26.00
27.00	Administrative & General	5.00	5,474,724	0	5,474,724	240,052.00	22.81	27.00
28.00	Administrative & General under contract (see inst.)		3,188,497	0	3,188,497	14,332.00	222.47	28.00
29.00	Maintenance & Repairs	6.00	994	0	994	60.00	16.57	29.00
30.00	Operation of Plant	7.00	1,096,192	0	1,096,192	49,477.00	22.16	30.00
31.00	Laundry & Linen Service	8.00	41,595	0	41,595	4,006.00	10.38	31.00
32.00	Housekeeping	9.00	882,224	0	882,224	72,125.00	12.23	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	759,606	-523,465	236,141	17,292.00	13.66	34.00
35.00	Dietary under contract (see instructions)		424,079	0	424,079	17,303.00	24.51	35.00
36.00	Cafeteria	11.00	0	257,156	257,156	20,115.00	12.78	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	967,377	0	967,377	38,669.00	25.02	38.00
39.00	Central Services and Supply	14.00	234,464	0	234,464	17,038.00	13.76	39.00
40.00	Pharmacy	15.00	1,086,804	0	1,086,804	30,799.00	35.29	40.00
41.00	Medical Records & Medical Records Library	16.00	707,951	0	707,951	41,994.00	16.86	41.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part II Date/Time Prepared: 5/22/2014 7:57 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
42.00	Social Service	17.00	157,308	0	157,308	7,035.00	22.36	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part III Date/Time Prepared: 5/22/2014 7:57 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		41,115,470	0	41,115,470	1,618,515.00	25.40	1.00
2.00	Excluded area salaries (see instructions)		4,243,033	266,309	4,509,342	210,527.00	21.42	2.00
3.00	Subtotal salaries (line 1 minus line 2)		36,872,437	-266,309	36,606,128	1,407,988.00	26.00	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,722,766	0	1,722,766	36,811.00	46.80	4.00
5.00	Subtotal wage-related costs (see inst.)		10,844,393	0	10,844,393	0.00	29.62	5.00
6.00	Total (sum of lines 3 thru 5)		49,439,596	-266,309	49,173,287	1,444,799.00	34.03	6.00
7.00	Total overhead cost (see instructions)		15,097,703	-266,309	14,831,394	572,328.00	25.91	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part IV Date/Time Prepared: 5/22/2014 7:57 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	815,827	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1,989,849	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)	5,799,746	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)	32,172	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)	83,060	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	662,805	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	2,745,480	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	84,463	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	63,831	22.00
23.00	Tuition Reimbursement	44,605	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	12,321,838	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: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part V | Date/Time Prepared: 5/22/2014 7:57 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	1,413,660	0	1.00
2.00	Hospital	1,413,660	0	2.00
3.00	Subprovider - IPF	0	0	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	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 140013 | Component CCN: 147049 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-4 | Date/Time Prepared: 5/22/2014 7:57 pm

Home Health Agency I | PPS

		1.00	
0.00	County	PEORIA	0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	239.00	6.00	186.00	431.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	1.00	0.00	1.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		1.04	0.00	1.04	5.00
6.00	Direct Nursing Service		5.40	0.00	5.40	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		4			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		37900			20.00
20.01			99914			20.01
20.02			99919			20.02
20.03			99926			20.03

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	913	208	140	57	1,318	21.00
22.00	Skilled Nursing Visit Charges	209,670	49,887	28,679	13,255	301,491	22.00
23.00	Physical Therapy Visits	1,354	17	41	32	1,444	23.00
24.00	Physical Therapy Visit Charges	397,500	5,100	11,100	9,600	423,300	24.00
25.00	Occupational Therapy Visits	265	4	5	0	274	25.00
26.00	Occupational Therapy Visit Charges	78,900	1,200	1,500	0	81,600	26.00
27.00	Speech Pathology Visits	10	0	0	3	13	27.00
28.00	Speech Pathology Visit Charges	3,000	0	0	900	3,900	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	0	0	0	0	0	31.00
32.00	Home Health Aide Visit Charges	0	0	0	0	0	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,542	229	186	92	3,049	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	689,070	56,187	41,279	23,755	810,291	35.00
36.00	Total Number of Episodes (standard/non outlier)	204		54	6	264	36.00
37.00	Total Number of Outlier Episodes		6		1	7	37.00
38.00	Total Non-Routine Medical Supply Charges	2,591	831	180	106	3,708	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider CCN: 140013	Period: From 01/01/2013 To 12/31/2013	Worksheet S-7 Date/Time Prepared: 5/22/2014 7:57 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N		2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	10	0	10	3.00
4.00		RUL	8	0	8	4.00
5.00		RVX	36	0	36	5.00
6.00		RVL	8	0	8	6.00
7.00		RHX	6	0	6	7.00
8.00		RHL	40	0	40	8.00
9.00		RMX	33	0	33	9.00
10.00		RML	2	0	2	10.00
11.00		RLX	16	0	16	11.00
12.00		RUC	92	0	92	12.00
13.00		RUB	248	0	248	13.00
14.00		RUA	470	0	470	14.00
15.00		RVC	311	0	311	15.00
16.00		RVB	369	0	369	16.00
17.00		RVA	676	0	676	17.00
18.00		RHC	76	0	76	18.00
19.00		RHB	66	0	66	19.00
20.00		RHA	204	0	204	20.00
21.00		RMC	30	0	30	21.00
22.00		RMB	28	0	28	22.00
23.00		RMA	128	0	128	23.00
24.00		RLB	8	0	8	24.00
25.00		RLA	9	0	9	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	38	0	38	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	6	0	6	32.00
33.00		HC2	9	0	9	33.00
34.00		HC1	1	0	1	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	112	0	112	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	14	0	14	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	3	0	3	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	10	0	10	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	1	0	1	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	10	0	10	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	0	0	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-7 | Date/Time Prepared: 5/22/2014 7:57 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	3	0	3	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	9	0	9	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	6	0	6	199.00
200.00	TOTAL		3,096	0	3,096	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	37900	37900	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	1,052,404	36.85	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	2,855,791			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-10 | Date/Time Prepared: 5/22/2014 7:57 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.276145	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,017,728	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	19,469,018	6.00
7.00	Medicaid cost (line 1 times line 6)	5,376,272	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	3,358,544	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)	3,358,544	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		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	427,527	1,621,866	2,049,393	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	118,059	447,870	565,929	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	118,059	447,870	565,929	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	7,169,867	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	478,856	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	6,691,011	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,847,689	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,413,618	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,772,162	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A | Date/Time Prepared: 5/22/2014 7:57 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	CAP REL COSTS-BLDG & FIXT		3,400,929	3,400,929	-181,498	3,219,431	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,397,749	4,397,749	0	4,397,749	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	75,888	10,066,998	10,142,886	19,941	10,162,827	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,474,724	14,322,548	19,797,272	-169,039	19,628,233	5.00
6.00	00600	MAINTENANCE & REPAIRS	994	1,261,228	1,262,222	75,291	1,337,513	6.00
7.00	00700	OPERATION OF PLANT	1,096,192	673,025	1,769,217	81,640	1,850,857	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	41,595	425,983	467,578	0	467,578	8.00
9.00	00900	HOUSEKEEPING	882,224	212,889	1,095,113	140,135	1,235,248	9.00
10.00	01000	DIETARY	759,606	1,206,498	1,966,104	-1,354,897	611,207	10.00
11.00	01100	CAFETERIA	0	0	0	665,601	665,601	11.00
13.00	01300	NURSING ADMINISTRATION	967,377	44,902	1,012,279	0	1,012,279	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	234,464	445,067	679,531	-421,177	258,354	14.00
15.00	01500	PHARMACY	1,086,804	434,244	1,521,048	-60,578	1,460,470	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	707,951	2,298,957	3,006,908	0	3,006,908	16.00
17.00	01700	SOCIAL SERVICE	157,308	14,134	171,442	0	171,442	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,361,656	1,097,329	7,458,985	-870,419	6,588,566	30.00
31.00	03100	INTENSIVE CARE UNIT	1,524,771	241,034	1,765,805	-145,613	1,620,192	31.00
40.00	04000	SUBPROVIDER - IPF	820,440	813,155	1,633,595	0	1,633,595	40.00
43.00	04300	NURSERY	0	0	0	325,028	325,028	43.00
44.00	04400	SKILLED NURSING FACILITY	1,058,063	108,814	1,166,877	43,608	1,210,485	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,246,939	13,480,468	17,727,407	-11,471,419	6,255,988	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	910,261	443,258	1,353,519	-113,862	1,239,657	52.00
53.00	05300	ANESTHESIOLOGY	44,726	315,659	360,385	-293,965	66,420	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,568,574	1,758,060	3,326,634	-252,429	3,074,205	54.00
60.00	06000	LABORATORY	1,519,599	2,592,765	4,112,364	-194,088	3,918,276	60.00
65.00	06500	RESPIRATORY THERAPY	1,026,870	149,324	1,176,194	-57,164	1,119,030	65.00
66.00	06600	PHYSICAL THERAPY	236,699	2,118,384	2,355,083	-366,482	1,988,601	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	994,220	5,988,295	6,982,515	-3,867,323	3,115,192	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,137,244	7,137,244	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,040,955	11,040,955	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,715,284	2,715,284	-38,047	2,677,237	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	187,475	128,390	315,865	-1,284	314,581	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	940,016	1,298,211	2,238,227	-418	2,237,809	90.00
91.00	09100	EMERGENCY	2,212,928	67,990	2,280,918	-231,997	2,048,921	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	386,914	283,529	670,443	0	670,443	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	35,525,278	72,805,100	108,330,378	-562,256	107,768,122	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	9,580	9,580	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	347,987	347,987	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	423,469	56,240	479,709	63,301	543,010	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	699,603	305,202	1,004,805	141,388	1,146,193	194.09
194.10	07960	ARC INGALLS	854,544	218,895	1,073,439	0	1,073,439	194.10
200.00		TOTAL (SUM OF LINES 118-199)	37,502,894	73,385,437	110,888,331	0	110,888,331	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A | Date/Time Prepared: 5/22/2014 7:57 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-230,421	2,989,010		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-2,319	4,395,430		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,360,998	8,801,829		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,437,589	18,190,644		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,337,513		6.00
7.00	00700	OPERATION OF PLANT	-67,178	1,783,679		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-5,435	462,143		8.00
9.00	00900	HOUSEKEEPING	0	1,235,248		9.00
10.00	01000	DIETARY	0	611,207		10.00
11.00	01100	CAFETERIA	0	665,601		11.00
13.00	01300	NURSING ADMINISTRATION	-1,622	1,010,657		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	258,354		14.00
15.00	01500	PHARMACY	0	1,460,470		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,320	2,999,588		16.00
17.00	01700	SOCIAL SERVICE	0	171,442		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-570,487	6,018,079		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,620,192		31.00
40.00	04000	SUBPROVIDER - IPF	0	1,633,595		40.00
43.00	04300	NURSERY	0	325,028		43.00
44.00	04400	SKILLED NURSING FACILITY	-6,000	1,204,485		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	6,255,988		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-277,425	962,232		52.00
53.00	05300	ANESTHESIOLOGY	0	66,420		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-7,398	3,066,807		54.00
60.00	06000	LABORATORY	-123,456	3,794,820		60.00
65.00	06500	RESPIRATORY THERAPY	-51	1,118,979		65.00
66.00	06600	PHYSICAL THERAPY	0	1,988,601		66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,115,192		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,137,244		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,040,955		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,677,237		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	-69,824	244,757		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-367,644	1,870,165		90.00
91.00	09100	EMERGENCY	-1,810,108	238,813		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	-1,129	669,314		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-6,346,404	101,421,718		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0		194.00
194.01	07951	MEALS ON WHEELS	0	0		194.01
194.02	07952	MARKETING	0	0		194.02
194.03	07953	GUEST MEALS	0	9,580		194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	347,987		194.04
194.05	07955	FOUNDATION	0	0		194.05
194.06	07956	DAYCARE CENTER	0	543,010		194.06
194.07	07957	UN-USED SQR FT - POB	0	0		194.07
194.08	07958	SENIOR SERVICES	0	0		194.08
194.09	07959	ARC BROMENN	0	1,146,193		194.09
194.10	07960	ARC INGALLS	0	1,073,439		194.10
200.00		TOTAL (SUM OF LINES 118-199)	-6,346,404	104,541,927		200.00

RECLASSIFICATIONS | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-6 | Date/Time Prepared: 5/22/2014 7:57 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	257,156	408,445	1.00
2.00	SKILLED NURSING FACILITY	44.00	49,082	77,958	2.00
3.00	GUEST MEALS	194.03	3,701	5,879	3.00
4.00	PHYSICIAN/OTHER MEALS	194.04	134,445	213,542	4.00
5.00	DAYCARE CENTER	194.06	24,456	38,845	5.00
6.00	ARC BROMENN	194.09	54,625	86,763	6.00
	TOTALS		523,465	831,432	
	B - POB EXPENSE				
1.00	EMPLOYEE BENEFITS	4.00	0	20,926	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	18,099	2.00
3.00	MAINTENANCE & REPAIRS	6.00	0	75,291	3.00
4.00	OPERATION OF PLANT	7.00	0	81,640	4.00
5.00	HOUSEKEEPING	9.00	0	140,135	5.00
	TOTALS		0	336,091	
	C - NURSERY RECLASS				
1.00	NURSERY	43.00	293,822	31,206	1.00
	TOTALS		293,822	31,206	
	D - INSURANCE RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	168,090	1.00
	TOTALS		0	168,090	
	E - BENEFITS				
1.00	EMPLOYEE BENEFITS	4.00	0	19,048	1.00
	TOTALS		0	19,048	
	F - DRUGS RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	20,033	1.00
	TOTALS		0	20,033	
	G - MED SUPPLIES RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	7,137,244	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		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
	TOTALS		0	7,137,244	
	H - LEASE EXPENSE RECLASS				
1.00		0.00	0	0	1.00
2.00	PHARMACY	15.00	0	1,806	2.00
3.00	OPERATING ROOM	50.00	0	11,691	3.00
	TOTALS		0	13,497	
	I - IMPLANTIBLE RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	11,040,955	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,018	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
	TOTALS		0	11,041,973	
500.00	Grand Total: Increases		817,287	19,598,614	500.00

RECLASSIFICATIONS | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-6 | Date/Time Prepared: 5/22/2014 7:57 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	523,465	831,432	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	TOTALS		523,465	831,432			
	B - POB EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	336,091	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	TOTALS		0	336,091			
	C - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	293,822	31,206	0		1.00
	TOTALS		293,822	31,206			
	D - INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	168,090	9		1.00
	TOTALS		0	168,090			
	E - BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	19,048	0		1.00
	TOTALS		0	19,048			
	F - DRUGS RECLASS						
1.00	EMPLOYEE BENEFITS	4.00	0	20,033	0		1.00
	TOTALS		0	20,033			
	G - MED SUPPLIES RECLASS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	421,177	0		1.00
2.00	PHARMACY	15.00	0	62,384	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	534,756	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	143,379	0		4.00
5.00	SKILLED NURSING FACILITY	44.00	0	82,814	0		5.00
6.00	OPERATING ROOM	50.00	0	3,688,848	0		6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	112,457	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	293,965	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	253,447	0		9.00
10.00	LABORATORY	60.00	0	194,088	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	57,164	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	115,599	0		12.00
13.00	ELECTROENCEPHALOGRAPHY	70.00	0	907,905	0		13.00
14.00	DRUGS CHARGED TO PATIENTS	73.00	0	58,080	0		14.00
15.00	CARDIAC REHABILITATION	76.97	0	1,284	0		15.00
16.00	CLINIC	90.00	0	418	0		16.00
17.00	EMERGENCY	91.00	0	209,479	0		17.00
	TOTALS		0	7,137,244			
	H - LEASE EXPENSE RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	13,497	11		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	13,497			
	I - IMPLANTIBLE RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	10,635	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	2,234	0		2.00
3.00	SKILLED NURSING FACILITY	44.00	0	618	0		3.00
4.00	OPERATING ROOM	50.00	0	7,794,262	0		4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,405	0		5.00
7.00	PHYSICAL THERAPY	66.00	0	250,883	0		7.00
8.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,959,418	0		8.00
9.00	EMERGENCY	91.00	0	22,518	0		9.00
	TOTALS		0	11,041,973			
500.00	Grand Total: Decreases		817,287	19,598,614			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-7 Part I Date/Time Prepared: 5/22/2014 7:57 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	773,664	0	0	0	0	1.00
2.00	Land Improvements	11,159,042	421,584	0	421,584	0	2.00
3.00	Buildings and Fixtures	53,278,856	4,044,530	0	4,044,530	0	3.00
4.00	Building Improvements	429,739	0	0	0	0	4.00
5.00	Fixed Equipment	19,160,298	24,664	0	24,664	0	5.00
6.00	Movable Equipment	55,583,590	1,163,316	0	1,163,316	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	140,385,189	5,654,094	0	5,654,094	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	140,385,189	5,654,094	0	5,654,094	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	773,664	0	1.00
2.00	Land Improvements	11,580,626	0	2.00
3.00	Buildings and Fixtures	57,323,386	0	3.00
4.00	Building Improvements	429,739	0	4.00
5.00	Fixed Equipment	19,184,962	0	5.00
6.00	Movable Equipment	56,746,906	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	146,039,283	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	146,039,283	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-7 Part II | Date/Time Prepared: 5/22/2014 7:57 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,400,929	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,397,749	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	7,798,678	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	3,400,929	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,397,749	2.00
3.00	Total (sum of lines 1-2)	0	7,798,678	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-7 Part III Date/Time Prepared: 5/22/2014 7:57 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	89,292,377	0	89,292,377	0.611427	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	56,746,906	0	56,746,906	0.388573	0	2.00
3.00	Total (sum of lines 1-2)	146,039,283	0	146,039,283	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	3,327,482	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	4,395,430	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	7,722,912	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	-277,691	-60,781	0	0	2,989,010	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	4,395,430	2.00
3.00	Total (sum of lines 1-2)	-277,691	-60,781	0	0	7,384,440	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-8 | Date/Time Prepared: 5/22/2014 7:57 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	-2,846,942			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	432,923			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	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	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)		0	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
33.00	A&G - MISC REVENUE	B	-447,711	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	PHYS BILLING OFFICE	B	-343,281	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-8 | Date/Time Prepared: 5/22/2014 7:57 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	HR - MISC REVENUE	B	-15	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	PLANT OP OTHER REV	B	-58,325	OPERATION OF PLANT	7.00	0	33.03
33.04	LAUNDRY REVENUE	B	-5,435	LAUNDRY & LINEN SERVICE	8.00	0	33.04
33.05	HEALTH PROMOTIONS	B	-1,340	NURSING ADMINISTRATION	13.00	0	33.05
33.06	SALE OF MEDICAL RECORDS	B	-7,320	MEDICAL RECORDS & LIBRARY	16.00	0	33.06
33.07	TRAINING FEES	B	-150	ADULTS & PEDIATRICS	30.00	0	33.07
33.08	MISC INCOME -A&P	B	-11,702	ADULTS & PEDIATRICS	30.00	0	33.08
33.09	LABOR AND DELIVERY REVENUE	B	-4,594	DELIVERY ROOM & LABOR ROOM	52.00	0	33.09
33.10	RADIOLOGY - MISC REVENUE	B	-7,398	RADIOLOGY-DIAGNOSTIC	54.00	0	33.10
33.11	LAB - MISC REV	B	-138	LABORATORY	60.00	0	33.11
33.12	CARDIAC REHAB - MISC REV	B	-62,324	CARDIAC REHABILITATION	76.97	0	33.12
33.13	COUNSELING CTR MISC REV	B	-13,368	CLINIC	90.00	0	33.13
33.14	EMERGENCY ROOM - MISC REVENUE	B	-45,379	EMERGENCY	91.00	0	33.14
33.16	HHA - MISC REVENUE	B	-902	HOME HEALTH AGENCY	101.00	0	33.16
33.17	INVESTMENT PROPERTY TAXES	A	-99,000	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	ADVERTISING A&G	A	-820,443	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	MARKETING A&G	A	-3,723	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	MARKETING - FAMILY MATERNITY CENTER	A	-5,565	ADULTS & PEDIATRICS	30.00	0	33.20
33.21	MARKETING - PROCTOR HOME HEALTH	A	-227	HOME HEALTH AGENCY	101.00	0	33.21
33.22			0		0.00	0	33.22
33.23	MARKETING - SLEEP LAB/EEG	A	-51	RESPIRATORY THERAPY	65.00	0	33.23
33.24	MARKETING - EMERGENCY ROOM	A	-115	EMERGENCY	91.00	0	33.24
33.25	MARKETING - COMMUNITY OUTREACH	A	-234,013	CLINIC	90.00	0	33.25
33.28	MARKETING - PATIENT SERVICES	A	-15	NURSING ADMINISTRATION	13.00	0	33.28
33.29	ENTERTAINMENT EXPENSE	A	-15,773	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.31	ENTERTAINMENT EXPENSE	A	-267	NURSING ADMINISTRATION	13.00	0	33.31
33.32	ENTERTAINMENT EXPENSE	A	-654	ADULTS & PEDIATRICS	30.00	0	33.32
33.35			0		0.00	0	33.35
33.37	INTEREST EXPENSE	A	-264,194	CAP REL COSTS-BLDG & FIXT	1.00	11	33.37
33.39	IHA DUES LOBBYING FFES	A	-27,004	ADMINISTRATIVE & GENERAL	5.00	0	33.39
33.40	POB SECURITY COST	A	-8,853	OPERATION OF PLANT	7.00	0	33.40
33.41	POB SECURITY COST	A	-2,452	EMPLOYEE BENEFITS	4.00	0	33.41
33.42	GRANT EXP OFFSET	A	-8,885	ADMINISTRATIVE & GENERAL	5.00	0	33.42
33.43	POB PROPERTY INSURANCE	A	-60,781	CAP REL COSTS-BLDG & FIXT	1.00	12	33.43
33.44	SELF FUNDED INSURANCE	A	-1,355,808	EMPLOYEE BENEFITS	4.00	0	33.44
33.45	TELEPHONE SERVICES - SALARIES	A	-10,123	ADMINISTRATIVE & GENERAL	5.00	0	33.45
33.46	TELEPHONE SERVICES - BENEFITS	A	-2,738	EMPLOYEE BENEFITS	4.00	0	33.46
33.47	TELEPHONE SERVICES - EQUIPMENT	A	-2,319	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.47
33.49			0		0.00	0	33.49
33.50			0		0.00	0	33.50
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,346,404				50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-8-1 | Date/Time Prepared: 5/22/2014 7:57 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	RENT EXPENSE	641,794	547,240	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	338,369	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			980,163	547,240	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		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
6.00	B		100.00	UNITY POINT	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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.

(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: 140013	Period: From 01/01/2013 To 12/31/2013	Worksheet A-8-1 Date/Time Prepared: 5/22/2014 7:57 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	94,554	9		1.00
2.00	338,369	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	432,923			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	HEALTH SYSTEM		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-8-2 | Date/Time Prepared: 5/22/2014 7:57 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	274,315	274,315	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	9,745	9,745	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	268,356	268,356	0	0	0	3.00
4.00	44.00	SKILLED NURSING FACILITY	6,000	6,000	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	272,831	272,831	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	60.00	LABORATORY	74,124	0	74,124	219,500	1,040	7.00
8.00	60.00	LABORATORY	123,318	123,318	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	76.97	CARDIAC REHABILITATION	7,500	7,500	0	0	0	10.00
11.00	90.00	CLINIC	1,958	1,958	0	0	0	11.00
12.00	90.00	CLINIC	25,075	25,075	0	0	0	12.00
13.00	90.00	CLINIC	8,700	8,700	0	0	0	13.00
14.00	90.00	CLINIC	58,520	58,520	0	0	0	14.00
15.00	90.00	CLINIC	26,010	26,010	0	0	0	15.00
16.00	91.00	EMERGENCY	1,754,614	1,754,614	0	0	0	16.00
17.00	91.00	EMERGENCY	10,000	10,000	0	0	0	17.00
200.00			2,921,066	2,846,942	74,124		1,040	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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	44.00	SKILLED NURSING FACILITY	0	0	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	60.00	LABORATORY	109,750	5,488	0	0	0	7.00
8.00	60.00	LABORATORY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	10.00
11.00	90.00	CLINIC	0	0	0	0	0	11.00
12.00	90.00	CLINIC	0	0	0	0	0	12.00
13.00	90.00	CLINIC	0	0	0	0	0	13.00
14.00	90.00	CLINIC	0	0	0	0	0	14.00
15.00	90.00	CLINIC	0	0	0	0	0	15.00
16.00	91.00	EMERGENCY	0	0	0	0	0	16.00
17.00	91.00	EMERGENCY	0	0	0	0	0	17.00
200.00			109,750	5,488	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	274,315		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	9,745		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	268,356		3.00
4.00	44.00	SKILLED NURSING FACILITY	0	0	0	6,000		4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	272,831		5.00
6.00	0.00		0	0	0	0		6.00
7.00	60.00	LABORATORY	0	109,750	0	0		7.00
8.00	60.00	LABORATORY	0	0	0	123,318		8.00
9.00	0.00		0	0	0	0		9.00
10.00	76.97	CARDIAC REHABILITATION	0	0	0	7,500		10.00
11.00	90.00	CLINIC	0	0	0	1,958		11.00
12.00	90.00	CLINIC	0	0	0	25,075		12.00
13.00	90.00	CLINIC	0	0	0	8,700		13.00
14.00	90.00	CLINIC	0	0	0	58,520		14.00
15.00	90.00	CLINIC	0	0	0	26,010		15.00
16.00	91.00	EMERGENCY	0	0	0	1,754,614		16.00
17.00	91.00	EMERGENCY	0	0	0	10,000		17.00
200.00			0	109,750	0	2,846,942		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part I Date/Time Prepared: 5/22/2014 7:57 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,989,010	2,989,010				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,395,430		4,395,430			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,801,829	106,069	155,978	9,063,876		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,190,644	323,749	476,082	1,318,013	20,308,488	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,337,513	478,863	704,182	241	2,520,799	6.00
7.00	00700	OPERATION OF PLANT	1,783,679	34,093	50,134	263,666	2,131,572	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	462,143	27,625	40,623	10,086	540,477	8.00
9.00	00900	HOUSEKEEPING	1,235,248	46,807	68,831	213,928	1,564,814	9.00
10.00	01000	DIETARY	611,207	36,670	53,924	57,261	759,062	10.00
11.00	01100	CAFETERIA	665,601	104,145	153,148	62,357	985,251	11.00
13.00	01300	NURSING ADMINISTRATION	1,010,657	16,784	24,682	234,576	1,286,699	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	258,354	0	0	56,854	315,208	14.00
15.00	01500	PHARMACY	1,460,470	23,662	34,795	263,536	1,782,463	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,999,588	26,533	39,018	171,669	3,236,808	16.00
17.00	01700	SOCIAL SERVICE	171,442	1,027	1,510	38,145	212,124	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,018,079	439,014	645,583	1,471,371	8,574,047	30.00
31.00	03100	INTENSIVE CARE UNIT	1,620,192	65,321	96,057	369,737	2,151,307	31.00
40.00	04000	SUBPROVIDER - IPF	1,633,595	50,080	73,645	198,946	1,956,266	40.00
43.00	04300	NURSERY	325,028	8,220	12,088	71,248	416,584	43.00
44.00	04400	SKILLED NURSING FACILITY	1,204,485	116,285	171,000	268,468	1,760,238	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,255,988	303,396	446,154	1,029,827	8,035,365	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	962,232	23,798	34,996	220,726	1,241,752	52.00
53.00	05300	ANESTHESIOLOGY	66,420	4,975	7,316	10,845	89,556	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,066,807	196,732	289,300	380,359	3,933,198	54.00
60.00	06000	LABORATORY	3,794,820	83,613	122,956	368,483	4,369,872	60.00
65.00	06500	RESPIRATORY THERAPY	1,118,979	30,489	44,835	249,003	1,443,306	65.00
66.00	06600	PHYSICAL THERAPY	1,988,601	8,615	12,668	57,396	2,067,280	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,115,192	63,132	92,837	241,085	3,512,246	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,137,244	80,957	119,050	0	7,337,251	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,040,955	0	0	0	11,040,955	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,677,237	0	0	0	2,677,237	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	244,757	17,409	25,600	45,460	333,226	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,870,165	60,554	89,047	227,942	2,247,708	90.00
91.00	09100	EMERGENCY	238,813	82,673	121,573	536,606	979,665	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	669,314	5,456	8,023	93,822	776,615	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	101,421,718	2,866,746	4,215,635	8,531,656	100,587,439	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	32,549	47,865	0	80,414	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	1,486	2,185	0	3,671	194.02
194.03	07953	GUEST MEALS	9,580	0	0	897	10,477	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	347,987	0	0	32,601	380,588	194.04
194.05	07955	FOUNDATION	0	18,816	27,670	0	46,486	194.05
194.06	07956	DAYCARE CENTER	543,010	65,730	96,659	108,616	814,015	194.06
194.07	07957	UN-USED SQR FT - POB	0	3,683	5,416	0	9,099	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	1,146,193	0	0	182,890	1,329,083	194.09
194.10	07960	ARC INGALLS	1,073,439	0	0	207,216	1,280,655	194.10
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	104,541,927	2,989,010	4,395,430	9,063,876	104,541,927	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part I | Date/Time Prepared: 5/22/2014 7:57 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,308,488					5.00
6.00	00600	MAINTENANCE & REPAIRS	607,760	3,128,559				6.00
7.00	00700	OPERATION OF PLANT	513,918	51,271	2,696,761			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	130,308	41,544	36,407	748,736		8.00
9.00	00900	HOUSEKEEPING	377,274	70,392	61,687	0	2,074,167	9.00
10.00	01000	DIETARY	183,008	55,147	48,328	0	38,574	10.00
11.00	01100	CAFETERIA	237,542	156,621	137,254	0	109,551	11.00
13.00	01300	NURSING ADMINISTRATION	310,221	25,242	22,120	0	17,656	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	75,996	0	0	0	0	14.00
15.00	01500	PHARMACY	429,748	35,584	31,184	0	24,890	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	780,388	39,903	34,969	0	27,911	16.00
17.00	01700	SOCIAL SERVICE	51,143	1,544	1,353	0	1,080	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,067,186	660,223	578,584	483,338	461,802	30.00
31.00	03100	INTENSIVE CARE UNIT	518,676	98,235	86,088	51,554	68,712	31.00
40.00	04000	SUBPROVIDER - IPF	471,652	75,315	66,001	75,026	52,680	40.00
43.00	04300	NURSERY	100,438	12,362	10,833	27,641	8,647	43.00
44.00	04400	SKILLED NURSING FACILITY	424,390	174,878	153,253	111,177	122,321	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,937,310	456,271	399,850	0	319,147	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	299,384	35,790	31,364	0	25,034	52.00
53.00	05300	ANESTHESIOLOGY	21,592	7,482	6,557	0	5,233	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	948,286	295,860	259,275	0	206,945	54.00
60.00	06000	LABORATORY	1,053,567	125,744	110,195	0	87,954	60.00
65.00	06500	RESPIRATORY THERAPY	347,978	45,852	40,182	0	32,072	65.00
66.00	06600	PHYSICAL THERAPY	498,417	12,956	11,353	0	9,062	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	846,795	94,942	83,202	0	66,409	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,768,997	121,749	106,694	0	85,160	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,661,926	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	645,476	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	80,340	26,181	22,943	0	18,313	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	541,918	91,066	79,805	0	63,698	90.00
91.00	09100	EMERGENCY	236,195	124,330	108,955	0	86,965	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	187,240	8,205	7,191	0	5,739	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,355,069	2,944,689	2,535,627	748,736	1,945,555	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19,388	48,950	42,897	0	34,239	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	885	2,235	1,958	0	1,563	194.02
194.03	07953	GUEST MEALS	2,526	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	91,759	0	0	0	0	194.04
194.05	07955	FOUNDATION	11,208	28,297	24,798	0	19,793	194.05
194.06	07956	DAYCARE CENTER	196,257	98,850	86,627	0	69,143	194.06
194.07	07957	UN-USED SQR FT - POB	2,194	5,538	4,854	0	3,874	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	320,439	0	0	0	0	194.09
194.10	07960	ARC INGALLS	308,763	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	20,308,488	3,128,559	2,696,761	748,736	2,074,167	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part I | Date/Time Prepared: 5/22/2014 7:57 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	1,084,119					10.00
11.00	01100	CAFETERIA	0	1,626,219				11.00
13.00	01300	NURSING ADMINISTRATION	0	58,506	1,720,444			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,180	0	405,384		14.00
15.00	01500	PHARMACY	0	65,729	0	3,760	2,373,358	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	42,816	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	9,514	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	859,125	366,964	544,156	30,380	3,523	30.00
31.00	03100	INTENSIVE CARE UNIT	91,637	92,217	136,741	8,643	191	31.00
40.00	04000	SUBPROVIDER - IPF	133,357	49,619	73,577	1,855	245	40.00
43.00	04300	NURSERY	0	17,770	26,350	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	66,959	99,289	4,992	1,366	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	256,851	380,865	222,360	33,651	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	55,052	81,632	6,779	1,559	52.00
53.00	05300	ANESTHESIOLOGY	0	2,705	4,011	17,720	576	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	94,866	140,670	15,278	68,668	54.00
60.00	06000	LABORATORY	0	91,904	0	11,699	1,461	60.00
65.00	06500	RESPIRATORY THERAPY	0	62,104	0	3,446	2,132	65.00
66.00	06600	PHYSICAL THERAPY	0	14,315	0	6,968	12,884	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	60,129	0	54,548	39,855	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,501	2,205,339	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	11,338	0	77	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	49	76	90.00
91.00	09100	EMERGENCY	0	133,836	198,455	12,627	956	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	23,400	34,698	435	876	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,084,119	1,590,774	1,720,444	405,117	2,373,358	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	224	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	8,131	0	0	0	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	0	27,090	0	102	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	110	0	194.09
194.10	07960	ARC INGALLS	0	0	0	55	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,084,119	1,626,219	1,720,444	405,384	2,373,358	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part I Date/Time Prepared: 5/22/2014 7:57 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,162,795					16.00
17.00	01700	SOCIAL SERVICE	0	276,758				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	372,795	185,506	15,187,629	0	15,187,629	30.00
31.00	03100	INTENSIVE CARE UNIT	70,525	19,787	3,394,313	0	3,394,313	31.00
40.00	04000	SUBPROVIDER - IPF	59,598	28,795	3,043,986	0	3,043,986	40.00
43.00	04300	NURSERY	18,596	0	639,221	0	639,221	43.00
44.00	04400	SKILLED NURSING FACILITY	33,097	42,670	2,994,630	0	2,994,630	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	790,470	0	12,832,140	0	12,832,140	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,682	0	1,799,028	0	1,799,028	52.00
53.00	05300	ANESTHESIOLOGY	164,869	0	320,301	0	320,301	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	571,595	0	6,534,641	0	6,534,641	54.00
60.00	06000	LABORATORY	378,139	0	6,230,535	0	6,230,535	60.00
65.00	06500	RESPIRATORY THERAPY	88,469	0	2,065,541	0	2,065,541	65.00
66.00	06600	PHYSICAL THERAPY	119,567	0	2,752,802	0	2,752,802	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	332,357	0	5,090,483	0	5,090,483	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	233,708	0	9,653,559	0	9,653,559	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	292,480	0	13,995,361	0	13,995,361	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	272,528	0	5,804,081	0	5,804,081	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	3,173	0	495,591	0	495,591	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	68,686	0	3,093,006	0	3,093,006	90.00
91.00	09100	EMERGENCY	257,992	0	2,139,976	0	2,139,976	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	13,469	0	1,057,868	0	1,057,868	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,162,795	276,758	99,124,692	0	99,124,692	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	225,888	0	225,888	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	10,312	0	10,312	194.02
194.03	07953	GUEST MEALS	0	0	13,227	0	13,227	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	480,478	0	480,478	194.04
194.05	07955	FOUNDATION	0	0	130,582	0	130,582	194.05
194.06	07956	DAYCARE CENTER	0	0	1,292,084	0	1,292,084	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	25,559	0	25,559	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	1,649,632	0	1,649,632	194.09
194.10	07960	ARC INGALLS	0	0	1,589,473	0	1,589,473	194.10
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,162,795	276,758	104,541,927	0	104,541,927	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part II Date/Time Prepared: 5/22/2014 7:57 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	106,069	155,978	262,047	262,047	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	323,749	476,082	799,831	38,108	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	478,863	704,182	1,183,045	7	6.00
7.00	00700	OPERATION OF PLANT	0	34,093	50,134	84,227	7,623	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	27,625	40,623	68,248	292	8.00
9.00	00900	HOUSEKEEPING	0	46,807	68,831	115,638	6,185	9.00
10.00	01000	DIETARY	0	36,670	53,924	90,594	1,656	10.00
11.00	01100	CAFETERIA	0	104,145	153,148	257,293	1,803	11.00
13.00	01300	NURSING ADMINISTRATION	0	16,784	24,682	41,466	6,782	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	1,644	14.00
15.00	01500	PHARMACY	0	23,662	34,795	58,457	7,620	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	26,533	39,018	65,551	4,963	16.00
17.00	01700	SOCIAL SERVICE	0	1,027	1,510	2,537	1,103	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	439,014	645,583	1,084,597	42,527	30.00
31.00	03100	INTENSIVE CARE UNIT	0	65,321	96,057	161,378	10,690	31.00
40.00	04000	SUBPROVIDER - IPF	0	50,080	73,645	123,725	5,752	40.00
43.00	04300	NURSERY	0	8,220	12,088	20,308	2,060	43.00
44.00	04400	SKILLED NURSING FACILITY	0	116,285	171,000	287,285	7,762	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	303,396	446,154	749,550	29,775	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	23,798	34,996	58,794	6,382	52.00
53.00	05300	ANESTHESIOLOGY	0	4,975	7,316	12,291	314	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	196,732	289,300	486,032	10,997	54.00
60.00	06000	LABORATORY	0	83,613	122,956	206,569	10,654	60.00
65.00	06500	RESPIRATORY THERAPY	0	30,489	44,835	75,324	7,199	65.00
66.00	06600	PHYSICAL THERAPY	0	8,615	12,668	21,283	1,659	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	63,132	92,837	155,969	6,970	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	80,957	119,050	200,007	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	17,409	25,600	43,009	1,314	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	60,554	89,047	149,601	6,590	90.00
91.00	09100	EMERGENCY	0	82,673	121,573	204,246	15,515	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	5,456	8,023	13,479	2,713	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,866,746	4,215,635	7,082,381	246,659	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	32,549	47,865	80,414	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	1,486	2,185	3,671	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	26	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	943	194.04
194.05	07955	FOUNDATION	0	18,816	27,670	46,486	0	194.05
194.06	07956	DAYCARE CENTER	0	65,730	96,659	162,389	3,140	194.06
194.07	07957	UN-USED SQR FT - POB	0	3,683	5,416	9,099	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	5,288	194.09
194.10	07960	ARC INGALLS	0	0	0	0	5,991	194.10
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	2,989,010	4,395,430	7,384,440	262,047	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part II | Date/Time Prepared: 5/22/2014 7:57 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	837,939					5.00
6.00	00600	MAINTENANCE & REPAIRS	25,077	1,208,129				6.00
7.00	00700	OPERATION OF PLANT	21,205	19,799	132,854			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,377	16,043	1,794	91,754		8.00
9.00	00900	HOUSEKEEPING	15,567	27,183	3,039	0	167,612	9.00
10.00	01000	DIETARY	7,551	21,296	2,381	0	3,117	10.00
11.00	01100	CAFETERIA	9,801	60,481	6,762	0	8,853	11.00
13.00	01300	NURSING ADMINISTRATION	12,800	9,747	1,090	0	1,427	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,136	0	0	0	0	14.00
15.00	01500	PHARMACY	17,732	13,741	1,536	0	2,011	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	32,200	15,409	1,723	0	2,255	16.00
17.00	01700	SOCIAL SERVICE	2,110	596	67	0	87	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	85,295	254,952	28,501	59,231	37,319	30.00
31.00	03100	INTENSIVE CARE UNIT	21,401	37,935	4,241	6,318	5,553	31.00
40.00	04000	SUBPROVIDER - IPF	19,461	29,084	3,252	9,194	4,257	40.00
43.00	04300	NURSERY	4,144	4,774	534	3,387	699	43.00
44.00	04400	SKILLED NURSING FACILITY	17,511	67,531	7,550	13,624	9,885	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	79,936	176,194	19,698	0	25,790	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,353	13,821	1,545	0	2,023	52.00
53.00	05300	ANESTHESIOLOGY	891	2,889	323	0	423	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39,127	114,250	12,773	0	16,723	54.00
60.00	06000	LABORATORY	43,471	48,557	5,429	0	7,107	60.00
65.00	06500	RESPIRATORY THERAPY	14,358	17,706	1,980	0	2,592	65.00
66.00	06600	PHYSICAL THERAPY	20,565	5,003	559	0	732	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	34,940	36,663	4,099	0	5,366	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	72,991	47,015	5,256	0	6,882	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	109,819	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,633	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	3,315	10,110	1,130	0	1,480	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	22,360	35,166	3,932	0	5,147	90.00
91.00	09100	EMERGENCY	9,746	48,011	5,368	0	7,028	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	7,726	3,169	354	0	464	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	798,599	1,137,125	124,916	91,754	157,220	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	800	18,903	2,113	0	2,767	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	37	863	96	0	126	194.02
194.03	07953	GUEST MEALS	104	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	3,786	0	0	0	0	194.04
194.05	07955	FOUNDATION	462	10,927	1,222	0	1,599	194.05
194.06	07956	DAYCARE CENTER	8,098	38,172	4,268	0	5,587	194.06
194.07	07957	UN-USED SQR FT - POB	91	2,139	239	0	313	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	13,222	0	0	0	0	194.09
194.10	07960	ARC INGALLS	12,740	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	837,939	1,208,129	132,854	91,754	167,612	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part II | Date/Time Prepared: 5/22/2014 7:57 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	126,595					10.00
11.00	01100	CAFETERIA	0	344,993				11.00
13.00	01300	NURSING ADMINISTRATION	0	12,411	85,723			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,008	0	7,788		14.00
15.00	01500	PHARMACY	0	13,944	0	72	115,113	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,083	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	2,018	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	100,322	77,855	27,118	584	171	30.00
31.00	03100	INTENSIVE CARE UNIT	10,701	19,563	6,813	166	9	31.00
40.00	04000	SUBPROVIDER - IPF	15,572	10,526	3,666	36	12	40.00
43.00	04300	NURSERY	0	3,770	1,313	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	14,205	4,947	96	66	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	54,488	18,975	4,273	1,632	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	11,679	4,067	130	76	52.00
53.00	05300	ANESTHESIOLOGY	0	574	200	340	28	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	20,125	7,008	293	3,331	54.00
60.00	06000	LABORATORY	0	19,496	0	225	71	60.00
65.00	06500	RESPIRATORY THERAPY	0	13,175	0	66	103	65.00
66.00	06600	PHYSICAL THERAPY	0	3,037	0	134	625	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	12,756	0	1,048	1,933	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	67	106,963	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	2,405	0	1	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	1	4	90.00
91.00	09100	EMERGENCY	0	28,392	9,887	243	46	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	4,964	1,729	8	43	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	126,595	337,474	85,723	7,783	115,113	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	47	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	1,725	0	0	0	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	0	5,747	0	2	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	2	0	194.09
194.10	07960	ARC INGALLS	0	0	0	1	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	126,595	344,993	85,723	7,788	115,113	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part II Date/Time Prepared: 5/22/2014 7:57 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	131,184					16.00
17.00	01700	SOCIAL SERVICE	0	8,518				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,733	5,710	1,815,915	0	1,815,915	30.00
31.00	03100	INTENSIVE CARE UNIT	2,220	609	287,597	0	287,597	31.00
40.00	04000	SUBPROVIDER - IPF	1,876	886	227,299	0	227,299	40.00
43.00	04300	NURSERY	585	0	41,574	0	41,574	43.00
44.00	04400	SKILLED NURSING FACILITY	1,042	1,313	432,817	0	432,817	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,045	0	1,185,356	0	1,185,356	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	651	0	111,521	0	111,521	52.00
53.00	05300	ANESTHESIOLOGY	5,189	0	23,462	0	23,462	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,990	0	728,649	0	728,649	54.00
60.00	06000	LABORATORY	11,901	0	353,480	0	353,480	60.00
65.00	06500	RESPIRATORY THERAPY	2,784	0	135,287	0	135,287	65.00
66.00	06600	PHYSICAL THERAPY	3,763	0	57,360	0	57,360	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,461	0	270,205	0	270,205	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,356	0	339,507	0	339,507	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,205	0	119,024	0	119,024	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,577	0	142,240	0	142,240	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	100	0	62,864	0	62,864	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,162	0	224,963	0	224,963	90.00
91.00	09100	EMERGENCY	8,120	0	336,602	0	336,602	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	424	0	35,073	0	35,073	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	131,184	8,518	6,930,795	0	6,930,795	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	104,997	0	104,997	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	4,793	0	4,793	194.02
194.03	07953	GUEST MEALS	0	0	177	0	177	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	6,454	0	6,454	194.04
194.05	07955	FOUNDATION	0	0	60,696	0	60,696	194.05
194.06	07956	DAYCARE CENTER	0	0	227,403	0	227,403	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	11,881	0	11,881	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	18,512	0	18,512	194.09
194.10	07960	ARC INGALLS	0	0	18,732	0	18,732	194.10
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	131,184	8,518	7,384,440	0	7,384,440	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B-1 | Date/Time Prepared: 5/22/2014 7:57 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	416,358					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		416,358				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	14,775	14,775	37,378,824			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	45,097	45,097	5,435,395	-20,308,488	84,233,439	5.00
6.00	00600	MAINTENANCE & REPAIRS	66,704	66,704	994	0	2,520,799	6.00
7.00	00700	OPERATION OF PLANT	4,749	4,749	1,087,339	0	2,131,572	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,848	3,848	41,595	0	540,477	8.00
9.00	00900	HOUSEKEEPING	6,520	6,520	882,224	0	1,564,814	9.00
10.00	01000	DIETARY	5,108	5,108	236,141	0	759,062	10.00
11.00	01100	CAFETERIA	14,507	14,507	257,156	0	985,251	11.00
13.00	01300	NURSING ADMINISTRATION	2,338	2,338	967,377	0	1,286,699	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	234,464	0	315,208	14.00
15.00	01500	PHARMACY	3,296	3,296	1,086,804	0	1,782,463	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,696	3,696	707,951	0	3,236,808	16.00
17.00	01700	SOCIAL SERVICE	143	143	157,308	0	212,124	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	61,153	61,153	6,067,834	0	8,574,047	30.00
31.00	03100	INTENSIVE CARE UNIT	9,099	9,099	1,524,771	0	2,151,307	31.00
40.00	04000	SUBPROVIDER - IPF	6,976	6,976	820,440	0	1,956,266	40.00
43.00	04300	NURSERY	1,145	1,145	293,822	0	416,584	43.00
44.00	04400	SKILLED NURSING FACILITY	16,198	16,198	1,107,145	0	1,760,238	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	42,262	42,262	4,246,939	0	8,035,365	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,315	3,315	910,261	0	1,241,752	52.00
53.00	05300	ANESTHESIOLOGY	693	693	44,726	0	89,556	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,404	27,404	1,568,574	0	3,933,198	54.00
60.00	06000	LABORATORY	11,647	11,647	1,519,599	0	4,369,872	60.00
65.00	06500	RESPIRATORY THERAPY	4,247	4,247	1,026,870	0	1,443,306	65.00
66.00	06600	PHYSICAL THERAPY	1,200	1,200	236,699	0	2,067,280	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,794	8,794	994,220	0	3,512,246	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,277	11,277	0	0	7,337,251	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	11,040,955	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,677,237	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,425	2,425	187,475	0	333,226	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8,435	8,435	940,016	0	2,247,708	90.00
91.00	09100	EMERGENCY	11,516	11,516	2,212,928	0	979,665	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	760	760	386,914	0	776,615	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	399,327	399,327	35,183,981	-20,308,488	80,278,951	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,534	4,534	0	0	80,414	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	207	207	0	0	3,671	194.02
194.03	07953	GUEST MEALS	0	0	3,701	0	10,477	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	134,445	0	380,588	194.04
194.05	07955	FOUNDATION	2,621	2,621	0	0	46,486	194.05
194.06	07956	DAYCARE CENTER	9,156	9,156	447,925	0	814,015	194.06
194.07	07957	UN-USED SQR FT - POB	513	513	0	0	9,099	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	754,228	0	1,329,083	194.09
194.10	07960	ARC INGALLS	0	0	854,544	0	1,280,655	194.10
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)	2,989,010	4,395,430	9,063,876		20,308,488	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.178942	10.556853	0.242487		0.241098	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			262,047		837,939	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.007011		0.009948	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B-1 | Date/Time Prepared: 5/22/2014 7:57 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	289,782					6.00
7.00	00700	OPERATION OF PLANT	4,749	285,033				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,848	3,848	30,528			8.00
9.00	00900	HOUSEKEEPING	6,520	6,520	0	274,665		9.00
10.00	01000	DIETARY	5,108	5,108	0	5,108	24,868	10.00
11.00	01100	CAFETERIA	14,507	14,507	0	14,507	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,338	2,338	0	2,338	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	3,296	3,296	0	3,296	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,696	3,696	0	3,696	0	16.00
17.00	01700	SOCIAL SERVICE	143	143	0	143	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	61,153	61,153	19,707	61,153	19,707	30.00
31.00	03100	INTENSIVE CARE UNIT	9,099	9,099	2,102	9,099	2,102	31.00
40.00	04000	SUBPROVIDER - IPF	6,976	6,976	3,059	6,976	3,059	40.00
43.00	04300	NURSERY	1,145	1,145	1,127	1,145	0	43.00
44.00	04400	SKILLED NURSING FACILITY	16,198	16,198	4,533	16,198	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	42,262	42,262	0	42,262	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,315	3,315	0	3,315	0	52.00
53.00	05300	ANESTHESIOLOGY	693	693	0	693	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,404	27,404	0	27,404	0	54.00
60.00	06000	LABORATORY	11,647	11,647	0	11,647	0	60.00
65.00	06500	RESPIRATORY THERAPY	4,247	4,247	0	4,247	0	65.00
66.00	06600	PHYSICAL THERAPY	1,200	1,200	0	1,200	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,794	8,794	0	8,794	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,277	11,277	0	11,277	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,425	2,425	0	2,425	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8,435	8,435	0	8,435	0	90.00
91.00	09100	EMERGENCY	11,516	11,516	0	11,516	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	760	760	0	760	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	272,751	268,002	30,528	257,634	24,868	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,534	4,534	0	4,534	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	207	207	0	207	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	2,621	2,621	0	2,621	0	194.05
194.06	07956	DAYCARE CENTER	9,156	9,156	0	9,156	0	194.06
194.07	07957	UN-USED SQR FT - POB	513	513	0	513	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,128,559	2,696,761	748,736	2,074,167	1,084,119	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.796250	9.461224	24.526205	7.551625	43.594941	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,208,129	132,854	91,754	167,612	126,595	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.169096	0.466100	3.005569	0.610242	5.090679	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B-1 | Date/Time Prepared: 5/22/2014 7:57 pm

		Cost Center Description	CAFETERIA (GROSS SALARIE)	NURSING ADMINISTRATION (NURSING SALARIE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	26,889,192					11.00
13.00	01300	NURSING ADMINISTRATION	967,377	19,184,354				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	234,464	0	6,725,140			14.00
15.00	01500	PHARMACY	1,086,804	0	62,384	2,859,650		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	707,951	0	0	0	358,959,246	16.00
17.00	01700	SOCIAL SERVICE	157,308	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,067,834	6,067,834	503,989	4,245	32,145,832	30.00
31.00	03100	INTENSIVE CARE UNIT	1,524,771	1,524,771	143,379	230	6,081,336	31.00
40.00	04000	SUBPROVIDER - IPF	820,440	820,440	30,767	295	5,139,120	40.00
43.00	04300	NURSERY	293,822	293,822	0	0	1,603,526	43.00
44.00	04400	SKILLED NURSING FACILITY	1,107,145	1,107,145	82,814	1,646	2,853,901	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,246,939	4,246,939	3,688,848	40,546	68,166,460	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	910,261	910,261	112,457	1,879	1,783,370	52.00
53.00	05300	ANESTHESIOLOGY	44,726	44,726	293,965	694	14,216,536	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,568,574	1,568,574	253,447	82,738	49,288,188	54.00
60.00	06000	LABORATORY	1,519,599	0	194,088	1,760	32,606,603	60.00
65.00	06500	RESPIRATORY THERAPY	1,026,870	0	57,164	2,569	7,628,582	65.00
66.00	06600	PHYSICAL THERAPY	236,699	0	115,599	15,524	10,310,191	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	994,220	0	904,923	48,021	28,658,914	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	20,152,471	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	25,220,296	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	58,080	2,657,204	23,499,835	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	187,475	0	1,284	0	273,568	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	814	91	5,922,727	90.00
91.00	09100	EMERGENCY	2,212,928	2,212,928	209,479	1,152	22,246,408	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	386,914	386,914	7,218	1,056	1,161,382	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	26,303,121	19,184,354	6,720,699	2,859,650	358,959,246	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	3,701	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	134,445	0	0	0	0	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	447,925	0	1,696	0	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	1,827	0	0	194.09
194.10	07960	ARC INGALLS	0	0	918	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,626,219	1,720,444	405,384	2,373,358	4,162,795	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.060479	0.089680	0.060279	0.829947	0.011597	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	344,993	85,723	7,788	115,113	131,184	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.012830	0.004468	0.001158	0.040254	0.000365	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B-1 | Date/Time Prepared: 5/22/2014 7:57 pm

		Cost Center Description	SOCIAL SERVICE (PATIENT DAYS) 17.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE	29,401		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	19,707		30.00
31.00	03100	INTENSIVE CARE UNIT	2,102		31.00
40.00	04000	SUBPROVIDER - IPF	3,059		40.00
43.00	04300	NURSERY	0		43.00
44.00	04400	SKILLED NURSING FACILITY	4,533		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
60.00	06000	LABORATORY	0		60.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0		76.00
76.97	07697	CARDIAC REHABILITATION	0		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,401		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0		194.00
194.01	07951	MEALS ON WHEELS	0		194.01
194.02	07952	MARKETING	0		194.02
194.03	07953	GUEST MEALS	0		194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0		194.04
194.05	07955	FOUNDATION	0		194.05
194.06	07956	DAYCARE CENTER	0		194.06
194.07	07957	UN-USED SQR FT - POB	0		194.07
194.08	07958	SENIOR SERVICES	0		194.08
194.09	07959	ARC BROMENN	0		194.09
194.10	07960	ARC INGALLS	0		194.10
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)	276,758		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.413217		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	8,518		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.289718		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,187,629		15,187,629	0	15,187,629	30.00
31.00	03100	INTENSIVE CARE UNIT	3,394,313		3,394,313	0	3,394,313	31.00
40.00	04000	SUBPROVIDER - IPF	3,043,986		3,043,986	0	3,043,986	40.00
43.00	04300	NURSERY	639,221		639,221	0	639,221	43.00
44.00	04400	SKILLED NURSING FACILITY	2,994,630		2,994,630	0	2,994,630	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,832,140		12,832,140	0	12,832,140	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,799,028		1,799,028	0	1,799,028	52.00
53.00	05300	ANESTHESIOLOGY	320,301		320,301	0	320,301	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,534,641		6,534,641	0	6,534,641	54.00
60.00	06000	LABORATORY	6,230,535		6,230,535	0	6,230,535	60.00
65.00	06500	RESPIRATORY THERAPY	2,065,541	0	2,065,541	0	2,065,541	65.00
66.00	06600	PHYSICAL THERAPY	2,752,802	0	2,752,802	0	2,752,802	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,090,483		5,090,483	0	5,090,483	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,653,559		9,653,559	0	9,653,559	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,995,361		13,995,361	0	13,995,361	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,804,081		5,804,081	0	5,804,081	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	495,591		495,591	0	495,591	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,093,006		3,093,006	0	3,093,006	90.00
91.00	09100	EMERGENCY	2,139,976		2,139,976	0	2,139,976	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,856,359		1,856,359		1,856,359	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,057,868		1,057,868		1,057,868	101.00
200.00		Subtotal (see instructions)	100,981,051	0	100,981,051	0	100,981,051	200.00
201.00		Less Observation Beds	1,856,359		1,856,359		1,856,359	201.00
202.00		Total (see instructions)	99,124,692	0	99,124,692	0	99,124,692	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,712,389		29,712,389			30.00
31.00	03100	INTENSIVE CARE UNIT	6,081,336		6,081,336			31.00
40.00	04000	SUBPROVIDER - IPF	5,139,120		5,139,120			40.00
43.00	04300	NURSERY	1,603,526		1,603,526			43.00
44.00	04400	SKILLED NURSING FACILITY	2,853,901		2,853,901			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,500,991	43,665,469	68,166,460	0.188247	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,631,137	152,233	1,783,370	1.008780	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	7,450,071	6,766,465	14,216,536	0.022530	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,388,945	41,899,243	49,288,188	0.132580	0.000000	54.00
60.00	06000	LABORATORY	9,332,434	23,274,169	32,606,603	0.191082	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,991,919	3,636,663	7,628,582	0.270763	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,317,432	3,992,759	10,310,191	0.266998	0.000000	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,889,293	17,769,621	28,658,914	0.177623	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,144,357	6,008,114	20,152,471	0.479026	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,158,010	9,062,286	25,220,296	0.554925	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,668,499	7,831,336	23,499,835	0.246984	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	664	272,904	273,568	1.811582	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	868	5,921,859	5,922,727	0.522227	0.000000	90.00
91.00	09100	EMERGENCY	5,864,413	16,381,995	22,246,408	0.096194	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	549,386	1,884,057	2,433,443	0.762853	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,161,382	1,161,382			101.00
200.00		Subtotal (see instructions)	169,278,691	189,680,555	358,959,246			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	169,278,691	189,680,555	358,959,246			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/22/2014 7:57 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
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.188247	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.008780	52.00
53.00	05300	ANESTHESIOLOGY	0.022530	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.132580	54.00
60.00	06000	LABORATORY	0.191082	60.00
65.00	06500	RESPIRATORY THERAPY	0.270763	65.00
66.00	06600	PHYSICAL THERAPY	0.266998	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.177623	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.479026	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.554925	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.246984	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	1.811582	76.97
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.522227	90.00
91.00	09100	EMERGENCY	0.096194	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.762853	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
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: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/22/2014 7:57 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,187,629		15,187,629	0	15,187,629	30.00
31.00	03100	INTENSIVE CARE UNIT	3,394,313		3,394,313	0	3,394,313	31.00
40.00	04000	SUBPROVIDER - IPF	3,043,986		3,043,986	0	3,043,986	40.00
43.00	04300	NURSERY	639,221		639,221	0	639,221	43.00
44.00	04400	SKILLED NURSING FACILITY	2,994,630		2,994,630	0	2,994,630	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,832,140		12,832,140	0	12,832,140	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,799,028		1,799,028	0	1,799,028	52.00
53.00	05300	ANESTHESIOLOGY	320,301		320,301	0	320,301	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,534,641		6,534,641	0	6,534,641	54.00
60.00	06000	LABORATORY	6,230,535		6,230,535	0	6,230,535	60.00
65.00	06500	RESPIRATORY THERAPY	2,065,541	0	2,065,541	0	2,065,541	65.00
66.00	06600	PHYSICAL THERAPY	2,752,802	0	2,752,802	0	2,752,802	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,090,483		5,090,483	0	5,090,483	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,653,559		9,653,559	0	9,653,559	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,995,361		13,995,361	0	13,995,361	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,804,081		5,804,081	0	5,804,081	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	495,591		495,591	0	495,591	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,093,006		3,093,006	0	3,093,006	90.00
91.00	09100	EMERGENCY	2,139,976		2,139,976	0	2,139,976	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,856,359		1,856,359		1,856,359	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,057,868		1,057,868		1,057,868	101.00
200.00		Subtotal (see instructions)	100,981,051	0	100,981,051	0	100,981,051	200.00
201.00		Less Observation Beds	1,856,359		1,856,359		1,856,359	201.00
202.00		Total (see instructions)	99,124,692	0	99,124,692	0	99,124,692	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/22/2014 7:57 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,712,389		29,712,389			30.00
31.00	03100	INTENSIVE CARE UNIT	6,081,336		6,081,336			31.00
40.00	04000	SUBPROVIDER - IPF	5,139,120		5,139,120			40.00
43.00	04300	NURSERY	1,603,526		1,603,526			43.00
44.00	04400	SKILLED NURSING FACILITY	2,853,901		2,853,901			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,500,991	43,665,469	68,166,460	0.188247	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,631,137	152,233	1,783,370	1.008780	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	7,450,071	6,766,465	14,216,536	0.022530	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,388,945	41,899,243	49,288,188	0.132580	0.000000	54.00
60.00	06000	LABORATORY	9,332,434	23,274,169	32,606,603	0.191082	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,991,919	3,636,663	7,628,582	0.270763	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,317,432	3,992,759	10,310,191	0.266998	0.000000	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,889,293	17,769,621	28,658,914	0.177623	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,144,357	6,008,114	20,152,471	0.479026	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,158,010	9,062,286	25,220,296	0.554925	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,668,499	7,831,336	23,499,835	0.246984	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	664	272,904	273,568	1.811582	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	868	5,921,859	5,922,727	0.522227	0.000000	90.00
91.00	09100	EMERGENCY	5,864,413	16,381,995	22,246,408	0.096194	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	549,386	1,884,057	2,433,443	0.762853	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,161,382	1,161,382			101.00
200.00		Subtotal (see instructions)	169,278,691	189,680,555	358,959,246			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	169,278,691	189,680,555	358,959,246			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/22/2014 7:57 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.188247		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.008780		52.00
53.00	05300	ANESTHESIOLOGY	0.022530		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.132580		54.00
60.00	06000	LABORATORY	0.191082		60.00
65.00	06500	RESPIRATORY THERAPY	0.270763		65.00
66.00	06600	PHYSICAL THERAPY	0.266998		66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.177623		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.479026		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.554925		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.246984		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	1.811582		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.522227		90.00
91.00	09100	EMERGENCY	0.096194		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.762853		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
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: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part II Date/Time Prepared: 5/22/2014 7:57 pm

Title XIX | Hospital | PPS

		Cost Center Description	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	12,832,140	1,185,356	11,646,784	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,799,028	111,521	1,687,507	0	0	52.00
53.00	05300	ANESTHESIOLOGY	320,301	23,462	296,839	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,534,641	728,649	5,805,992	0	0	54.00
60.00	06000	LABORATORY	6,230,535	353,480	5,877,055	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,065,541	135,287	1,930,254	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,752,802	57,360	2,695,442	0	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,090,483	270,205	4,820,278	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,653,559	339,507	9,314,052	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,995,361	119,024	13,876,337	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,804,081	142,240	5,661,841	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	495,591	62,864	432,727	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,093,006	224,963	2,868,043	0	0	90.00
91.00	09100	EMERGENCY	2,139,976	336,602	1,803,374	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,856,359	221,956	1,634,403	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,057,868	35,073	1,022,795	0	0	101.00
200.00		Subtotal (sum of lines 50 thru 199)	75,721,272	4,347,549	71,373,723	0	0	200.00
201.00		Less Observation Beds	1,856,359	221,956	1,634,403	0	0	201.00
202.00		Total (line 200 minus line 201)	73,864,913	4,125,593	69,739,320	0	0	202.00

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

Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part II Date/Time Prepared: 5/22/2014 7:57 pm

Title XIX | Hospital | PPS

		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	12,832,140	68,166,460	0.188247		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,799,028	1,783,370	1.008780		52.00
53.00	05300	ANESTHESIOLOGY	320,301	14,216,536	0.022530		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,534,641	49,288,188	0.132580		54.00
60.00	06000	LABORATORY	6,230,535	32,606,603	0.191082		60.00
65.00	06500	RESPIRATORY THERAPY	2,065,541	7,628,582	0.270763		65.00
66.00	06600	PHYSICAL THERAPY	2,752,802	10,310,191	0.266998		66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,090,483	28,658,914	0.177623		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,653,559	20,152,471	0.479026		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,995,361	25,220,296	0.554925		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,804,081	23,499,835	0.246984		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	495,591	273,568	1.811582		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	3,093,006	5,922,727	0.522227		90.00
91.00	09100	EMERGENCY	2,139,976	22,246,408	0.096194		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,856,359	2,433,443	0.762853		92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	1,057,868	1,161,382	0.910870		101.00
200.00		Subtotal (sum of lines 50 thru 199)	75,721,272	313,568,974			200.00
201.00		Less Observation Beds	1,856,359	0			201.00
202.00		Total (line 200 minus line 201)	73,864,913	313,568,974			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part I Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,815,915	0	1,815,915	22,368	81.18	30.00
31.00	INTENSIVE CARE UNIT	287,597		287,597	2,073	138.73	31.00
40.00	SUBPROVIDER - IPF	227,299	0	227,299	3,059	74.31	40.00
43.00	NURSERY	41,574		41,574	1,127	36.89	43.00
44.00	SKILLED NURSING FACILITY	432,817		432,817	4,530	95.54	44.00
200.00	Total (lines 30-199)	2,805,202		2,805,202	33,157		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	11,261	914,168				30.00
31.00	INTENSIVE CARE UNIT	1,317	182,707				31.00
40.00	SUBPROVIDER - IPF	2,495	185,403				40.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	3,096	295,792				44.00
200.00	Total (lines 30-199)	18,169	1,578,070				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part II Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,185,356	68,166,460	0.017389	11,653,751	202,647	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	111,521	1,783,370	0.062534	0	0	52.00
53.00	05300	ANESTHESIOLOGY	23,462	14,216,536	0.001650	3,171,583	5,233	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	728,649	49,288,188	0.014783	6,281,029	92,852	54.00
60.00	06000	LABORATORY	353,480	32,606,603	0.010841	6,435,043	69,762	60.00
65.00	06500	RESPIRATORY THERAPY	135,287	7,628,582	0.017734	2,473,367	43,863	65.00
66.00	06600	PHYSICAL THERAPY	57,360	10,310,191	0.005563	1,951,235	10,855	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	270,205	28,658,914	0.009428	6,421,037	60,538	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	339,507	20,152,471	0.016847	6,663,879	112,266	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	119,024	25,220,296	0.004719	8,190,389	38,650	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	142,240	23,499,835	0.006053	7,933,559	48,022	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	62,864	273,568	0.229793	664	153	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	224,963	5,922,727	0.037983	0	0	90.00
91.00	09100	EMERGENCY	336,602	22,246,408	0.015131	3,320,572	50,244	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	221,956	2,433,443	0.091211	262,083	23,905	92.00
200.00		Total (lines 50-199)	4,312,476	312,407,592		64,758,191	758,990	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part III Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,368	0.00	11,261	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,073	0.00	1,317	0		31.00
40.00	04000	SUBPROVIDER - IPF	3,059	0.00	2,495	0		40.00
43.00	04300	NURSERY	1,127	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	4,530	0.00	3,096	0		44.00
200.00		Total (lines 30-199)	33,157		18,169	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV | Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	68,166,460	0.000000	0.000000	11,653,751	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,783,370	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	14,216,536	0.000000	0.000000	3,171,583	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	49,288,188	0.000000	0.000000	6,281,029	54.00
60.00	06000	LABORATORY	0	32,606,603	0.000000	0.000000	6,435,043	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,628,582	0.000000	0.000000	2,473,367	65.00
66.00	06600	PHYSICAL THERAPY	0	10,310,191	0.000000	0.000000	1,951,235	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	28,658,914	0.000000	0.000000	6,421,037	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	20,152,471	0.000000	0.000000	6,663,879	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	25,220,296	0.000000	0.000000	8,190,389	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,499,835	0.000000	0.000000	7,933,559	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	273,568	0.000000	0.000000	664	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	5,922,727	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	22,246,408	0.000000	0.000000	3,320,572	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,433,443	0.000000	0.000000	262,083	92.00
200.00		Total (lines 50-199)	0	312,407,592			64,758,191	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV | Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	12,630,737	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	544	0		52.00
53.00	05300	ANESTHESIOLOGY	0	1,369,379	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,799,909	0		54.00
60.00	06000	LABORATORY	0	1,245,140	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,232,212	0		65.00
66.00	06600	PHYSICAL THERAPY	0	2,704,636	0		66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	9,543,308	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,833,204	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,311,433	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,083,234	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	147,906	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	179,064	0		90.00
91.00	09100	EMERGENCY	0	4,265,821	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	742,663	0		92.00
200.00		Total (lines 50-199)	0	53,089,190	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part V Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.188247	12,630,737	0	223	2,377,698	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.008780	544	0	0	549	52.00
53.00	05300	ANESTHESIOLOGY	0.022530	1,369,379	0	0	30,852	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.132580	11,799,909	0	3,963	1,564,432	54.00
60.00	06000	LABORATORY	0.191082	1,245,140	0	0	237,924	60.00
65.00	06500	RESPIRATORY THERAPY	0.270763	1,232,212	0	0	333,637	65.00
66.00	06600	PHYSICAL THERAPY	0.266998	2,704,636	0	8,140	722,132	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.177623	9,543,308	0	1,620	1,695,111	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.479026	1,833,204	0	0	878,152	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.554925	4,311,433	0	0	2,392,522	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.246984	1,083,234	0	28,254	267,541	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.811582	147,906	0	0	267,944	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.522227	179,064	0	0	93,512	90.00
91.00	09100	EMERGENCY	0.096194	4,265,821	0	147	410,346	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.762853	742,663	0	0	566,543	92.00
200.00		Subtotal (see instructions)		53,089,190	0	42,347	11,838,895	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		53,089,190	0	42,347	11,838,895	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part V Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	42		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	525		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	2,173		66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	288		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,978		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	14		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	10,020		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	10,020		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part II | Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,185,356	68,166,460	0.017389	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	111,521	1,783,370	0.062534	0	0	52.00
53.00	05300	ANESTHESIOLOGY	23,462	14,216,536	0.001650	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	728,649	49,288,188	0.014783	249,085	3,682	54.00
60.00	06000	LABORATORY	353,480	32,606,603	0.010841	347,613	3,768	60.00
65.00	06500	RESPIRATORY THERAPY	135,287	7,628,582	0.017734	120,366	2,135	65.00
66.00	06600	PHYSICAL THERAPY	57,360	10,310,191	0.005563	120,915	673	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	270,205	28,658,914	0.009428	35,262	332	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	339,507	20,152,471	0.016847	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	119,024	25,220,296	0.004719	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	142,240	23,499,835	0.006053	493,971	2,990	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	62,864	273,568	0.229793	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	224,963	5,922,727	0.037983	0	0	90.00
91.00	09100	EMERGENCY	336,602	22,246,408	0.015131	164,287	2,486	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,433,443	0.000000	0	0	92.00
200.00		Total (lines 50-199)	4,090,520	312,407,592		1,531,499	16,066	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV | Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV | Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	68,166,460	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,783,370	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	14,216,536	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	49,288,188	0.000000	0.000000	249,085	54.00
60.00	06000	LABORATORY	0	32,606,603	0.000000	0.000000	347,613	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,628,582	0.000000	0.000000	120,366	65.00
66.00	06600	PHYSICAL THERAPY	0	10,310,191	0.000000	0.000000	120,915	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	28,658,914	0.000000	0.000000	35,262	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	20,152,471	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	25,220,296	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,499,835	0.000000	0.000000	493,971	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	273,568	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	5,922,727	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	22,246,408	0.000000	0.000000	164,287	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,433,443	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	312,407,592			1,531,499	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV | Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	320	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	1,374	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	1,694	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part V | Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.188247	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.008780	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.022530	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.132580	320	0	10	42	54.00
60.00	06000	LABORATORY	0.191082	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.270763	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.266998	0	0	0	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.177623	0	0	6	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.479026	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.554925	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.246984	0	0	673	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.811582	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.522227	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.096194	1,374	0	0	132	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.762853	0	0	0	0	92.00
200.00		Subtotal (see instructions)		1,694	0	689	174	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		1,694	0	689	174	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part V | Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	166		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	168		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	168		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV | Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV | Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	68,166,460	0.000000	0.000000	2,232	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,783,370	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	14,216,536	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	49,288,188	0.000000	0.000000	41,365	54.00
60.00	06000	LABORATORY	0	32,606,603	0.000000	0.000000	249,627	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,628,582	0.000000	0.000000	218,589	65.00
66.00	06600	PHYSICAL THERAPY	0	10,310,191	0.000000	0.000000	2,121,639	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	28,658,914	0.000000	0.000000	44,858	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	20,152,471	0.000000	0.000000	51,225	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	25,220,296	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,499,835	0.000000	0.000000	871,327	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	273,568	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	5,922,727	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	22,246,408	0.000000	0.000000	69	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,433,443	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	312,407,592			3,600,931	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140013 Component CCN: 145579	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/22/2014 7:57 pm
	Title XVIII	Skilled Nursing Facility	PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part V | Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.188247	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.008780	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.022530	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.132580	0	0	0	0	54.00
60.00	06000	LABORATORY	0.191082	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.270763	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.266998	0	0	0	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.177623	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.479026	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.554925	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.246984	0	0	159	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.811582	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.522227	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.096194	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.762853	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	159	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	159	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140013 Component CCN: 145579	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/22/2014 7:57 pm
	Title XVIII	Skilled Nursing Facility	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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	39		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	39		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	39		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part I Date/Time Prepared: 5/22/2014 7:57 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,815,915	0	1,815,915	22,368	81.18	30.00
31.00	INTENSIVE CARE UNIT	287,597		287,597	2,073	138.73	31.00
40.00	SUBPROVIDER - IPF	227,299	0	227,299	3,059	74.31	40.00
43.00	NURSERY	41,574		41,574	1,127	36.89	43.00
44.00	SKILLED NURSING FACILITY	432,817		432,817	4,530	95.54	44.00
200.00	Total (lines 30-199)	2,805,202		2,805,202	33,157		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	868	70,464				30.00
31.00	INTENSIVE CARE UNIT	99	13,734				31.00
40.00	SUBPROVIDER - IPF	9	669				40.00
43.00	NURSERY	262	9,665				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30-199)	1,238	94,532				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part II Date/Time Prepared: 5/22/2014 7:57 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,185,356	68,166,460	0.017389	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	111,521	1,783,370	0.062534	0	0	52.00
53.00	05300	ANESTHESIOLOGY	23,462	14,216,536	0.001650	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	728,649	49,288,188	0.014783	0	0	54.00
60.00	06000	LABORATORY	353,480	32,606,603	0.010841	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	135,287	7,628,582	0.017734	0	0	65.00
66.00	06600	PHYSICAL THERAPY	57,360	10,310,191	0.005563	0	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	270,205	28,658,914	0.009428	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	339,507	20,152,471	0.016847	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	119,024	25,220,296	0.004719	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	142,240	23,499,835	0.006053	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	62,864	273,568	0.229793	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	224,963	5,922,727	0.037983	0	0	90.00
91.00	09100	EMERGENCY	336,602	22,246,408	0.015131	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	221,956	2,433,443	0.091211	0	0	92.00
200.00		Total (lines 50-199)	4,312,476	312,407,592		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part III Date/Time Prepared: 5/22/2014 7:57 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,368	0.00	868	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,073	0.00	99	0		31.00
40.00	04000	SUBPROVIDER - IPF	3,059	0.00	9	0		40.00
43.00	04300	NURSERY	1,127	0.00	262	0		43.00
44.00	04400	SKILLED NURSING FACILITY	4,530	0.00	0	0		44.00
200.00		Total (lines 30-199)	33,157		1,238	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV | Date/Time Prepared: 5/22/2014 7:57 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV | Date/Time Prepared: 5/22/2014 7:57 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	68,166,460	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,783,370	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	14,216,536	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	49,288,188	0.000000	0.000000	0	54.00
60.00	06000	LABORATORY	0	32,606,603	0.000000	0.000000	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,628,582	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	10,310,191	0.000000	0.000000	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	28,658,914	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	20,152,471	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	25,220,296	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,499,835	0.000000	0.000000	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	273,568	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	5,922,727	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	22,246,408	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,433,443	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	312,407,592			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV | Date/Time Prepared: 5/22/2014 7:57 pm

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part II | Date/Time Prepared: 5/22/2014 7:57 pm

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,185,356	68,166,460	0.017389	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	111,521	1,783,370	0.062534	0	0	52.00
53.00	05300	ANESTHESIOLOGY	23,462	14,216,536	0.001650	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	728,649	49,288,188	0.014783	0	0	54.00
60.00	06000	LABORATORY	353,480	32,606,603	0.010841	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	135,287	7,628,582	0.017734	0	0	65.00
66.00	06600	PHYSICAL THERAPY	57,360	10,310,191	0.005563	0	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	270,205	28,658,914	0.009428	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	339,507	20,152,471	0.016847	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	119,024	25,220,296	0.004719	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	142,240	23,499,835	0.006053	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	62,864	273,568	0.229793	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	224,963	5,922,727	0.037983	0	0	90.00
91.00	09100	EMERGENCY	336,602	22,246,408	0.015131	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,433,443	0.000000	0	0	92.00
200.00		Total (lines 50-199)	4,090,520	312,407,592		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140013 Component CCN: 14S013	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/22/2014 7:57 pm
	Title XIX	Subprovider - IPF	PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV | Date/Time Prepared: 5/22/2014 7:57 pm

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	68,166,460	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,783,370	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	14,216,536	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	49,288,188	0.000000	0.000000	0	54.00
60.00	06000	LABORATORY	0	32,606,603	0.000000	0.000000	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,628,582	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	10,310,191	0.000000	0.000000	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	28,658,914	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	20,152,471	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	25,220,296	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,499,835	0.000000	0.000000	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	273,568	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	5,922,727	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	22,246,408	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,433,443	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	312,407,592			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140013 Component CCN: 14S013	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/22/2014 7:57 pm
	Title XIX	Subprovider - IPF	PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV | Date/Time Prepared: 5/22/2014 7:57 pm

Title XIX | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV | Date/Time Prepared: 5/22/2014 7:57 pm

Title XIX | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	68,166,460	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,783,370	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	14,216,536	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	49,288,188	0.000000	0.000000	0	54.00
60.00	06000	LABORATORY	0	32,606,603	0.000000	0.000000	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,628,582	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	10,310,191	0.000000	0.000000	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	28,658,914	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	20,152,471	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	25,220,296	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,499,835	0.000000	0.000000	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	273,568	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	5,922,727	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	22,246,408	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,433,443	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	312,407,592			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140013 Component CCN: 145579	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/22/2014 7:57 pm
	Title XIX	Skilled Nursing Facility	PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	22,368	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	22,368	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)	19,634	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)	11,261	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)	15,187,629	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)	15,187,629	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)	15,187,629	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)	678.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	7,646,106	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)	7,646,106	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,394,313	2,073	1,637.39	1,317	2,156,443	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)	16,876,034	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	26,678,583	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)	1,096,875	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	758,990	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,855,865	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	24,822,718	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)	2,734	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	678.99	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,856,359	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,815,915	15,187,629	0.119565	1,856,359	221,956	90.00
91.00	Nursing School cost	0	15,187,629	0.000000	1,856,359	0	91.00
92.00	Allied health cost	0	15,187,629	0.000000	1,856,359	0	92.00
93.00	All other Medical Education	0	15,187,629	0.000000	1,856,359	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140013 Component CCN: 14S013	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/22/2014 7:57 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,059	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,059	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,059	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,495	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)	3,043,986	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)	3,043,986	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,043,986	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)	995.09	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,482,750	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,482,750	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	308,391	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,791,141	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)	185,403	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	16,066	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	201,469	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,589,672	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140013 Component CCN: 14S013	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/22/2014 7:57 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	227,299	3,043,986	0.074671	0	0	90.00
91.00	Nursing School cost	0	3,043,986	0.000000	0	0	91.00
92.00	Allied health cost	0	3,043,986	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,043,986	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140013 Component CCN: 145579	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/22/2014 7:57 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,530	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,530	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,530	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)	3,096	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)	2,994,630	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,994,630	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,994,630	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	2,994,630	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	661.07	71.00
72.00	Program routine service cost (line 9 x line 71)	2,046,673	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	2,046,673	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	2,046,673	83.00
84.00	Program inpatient ancillary services (see instructions)	926,979	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	2,973,652	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140013 Component CCN: 145579	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/22/2014 7:57 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/22/2014 7:57 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	22,368	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	22,368	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)	19,634	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)	868	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)	1,127	15.00
16.00	Nursery days (title V or XIX only)	262	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)	15,187,629	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)	15,187,629	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)	15,187,629	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)	678.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	589,363	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)	589,363	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/22/2014 7:57 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	639,221	1,127	567.19	262	148,604	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,394,313	2,073	1,637.39	99	162,102	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)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	900,069	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)	93,863	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	93,863	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	806,206	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)	2,734	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	678.99	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,856,359	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/22/2014 7:57 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,815,915	15,187,629	0.119565	1,856,359	221,956	90.00
91.00	Nursing School cost	0	15,187,629	0.000000	1,856,359	0	91.00
92.00	Allied health cost	0	15,187,629	0.000000	1,856,359	0	92.00
93.00	All other Medical Education	0	15,187,629	0.000000	1,856,359	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140013 Component CCN: 14S013	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/22/2014 7:57 pm
	Title XIX	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,059	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,059	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,059	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)	9	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)	1,127	15.00
16.00	Nursery days (title V or XIX only)	262	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)	3,043,986	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)	3,043,986	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,043,986	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)	995.09	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	8,956	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)	8,956	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/22/2014 7:57 pm

Title XIX | Subprovider - IPF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	8,956	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)	669	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	669	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	8,287	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140013 Component CCN: 14S013	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/22/2014 7:57 pm
	Title XIX	Subprovider - IPF	PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	227,299	3,043,986	0.074671	0	0	90.00
91.00	Nursing School cost	0	3,043,986	0.000000	0	0	91.00
92.00	Allied health cost	0	3,043,986	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,043,986	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140013 Component CCN: 145579	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/22/2014 7:57 pm
	Title XIX	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,530	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,530	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,530	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)	0	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)	1,127	15.00
16.00	Nursery days (title V or XIX only)	262	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)	2,994,630	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,994,630	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,994,630	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/22/2014 7:57 pm

Title XIX | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	2,994,630	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	661.07	71.00
72.00	Program routine service cost (line 9 x line 71)	0	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	0	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	432,817	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	95.54	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	0	83.00
84.00	Program inpatient ancillary services (see instructions)	0	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	0	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140013 Component CCN: 145579	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/22/2014 7:57 pm
	Title XIX	Skilled Nursing Facility	PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-3 | Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		12,264,546		30.00
31.00	03100	INTENSIVE CARE UNIT		3,512,201		31.00
40.00	04000	SUBPROVIDER - IPF		208,320		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.188247	11,653,751	2,193,784	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.008780	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.022530	3,171,583	71,456	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.132580	6,281,029	832,739	54.00
60.00	06000	LABORATORY	0.191082	6,435,043	1,229,621	60.00
65.00	06500	RESPIRATORY THERAPY	0.270763	2,473,367	669,696	65.00
66.00	06600	PHYSICAL THERAPY	0.266998	1,951,235	520,976	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.177623	6,421,037	1,140,524	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.479026	6,663,879	3,192,171	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.554925	8,190,389	4,545,052	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.246984	7,933,559	1,959,462	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.811582	664	1,203	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.522227	0	0	90.00
91.00	09100	EMERGENCY	0.096194	3,320,572	319,419	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.762853	262,083	199,931	92.00
200.00		Total (sum of lines 50-94 and 96-98)		64,758,191	16,876,034	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		64,758,191		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-3 | Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		4,204,991		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.188247	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.008780	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.022530	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.132580	249,085	33,024	54.00
60.00	06000	LABORATORY	0.191082	347,613	66,423	60.00
65.00	06500	RESPIRATORY THERAPY	0.270763	120,366	32,591	65.00
66.00	06600	PHYSICAL THERAPY	0.266998	120,915	32,284	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.177623	35,262	6,263	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.479026	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.554925	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.246984	493,971	122,003	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.811582	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.522227	0	0	90.00
91.00	09100	EMERGENCY	0.096194	164,287	15,803	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.762853	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,531,499	308,391	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,531,499		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-3 | Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.188247	2,232	420	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.008780	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.022530	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.132580	41,365	5,484	54.00
60.00	06000	LABORATORY	0.191082	249,627	47,699	60.00
65.00	06500	RESPIRATORY THERAPY	0.270763	218,589	59,186	65.00
66.00	06600	PHYSICAL THERAPY	0.266998	2,121,639	566,473	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.177623	44,858	7,968	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.479026	51,225	24,538	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.554925	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.246984	871,327	215,204	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.811582	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.522227	0	0	90.00
91.00	09100	EMERGENCY	0.096194	69	7	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.762853	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,600,931	926,979	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		3,600,931		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140013	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/22/2014 7:57 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)		0		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		18,821,666		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)		237,095		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)		134.51		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	Adjusment 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)		4.81		31.00
32.00	Sum of lines 30 and 31		4.81		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: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E Part A Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Hospital | PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
	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 an 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 an 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)		19,058,761		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)		19,058,761		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		1,527,171		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		21,237		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)		20,607,169		59.00
60.00	Primary payer payments		9,487		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		20,597,682		61.00
62.00	Deductibles billed to program beneficiaries		2,326,540		62.00
63.00	Coinsurance billed to program beneficiaries		25,048		63.00
64.00	Allowable bad debts (see instructions)		286,967		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		186,529		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		204,742		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		18,432,623		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)		-65,652		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		-74,218		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: 140013	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/22/2014 7:57 pm
	Title XVIII	Hospital	PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		18,292,753		71.00
71.01	Sequestration adjustment (see instructions)		276,221		71.01
72.00	Interim payments		17,931,286		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		85,246		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: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/22/2014 7:57 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	20,338,208	20,338,208	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013	1.01	0	0	0	0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013	1.02	18,821,666	0	0	18,821,666	18,821,666	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	237,095	0	0	237,095	237,095	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	19,058,761	0	0	19,058,761	19,058,761	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	19,058,761	0	0	19,058,761	19,058,761	15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50.00	1,527,171	0	0	1,527,171	1,527,171	16.00
17.00	Special add-on payments for new technologies	54.00	21,237	0	0	21,237	21,237	17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	0	20,607,169	20,607,169	19.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/22/2014 7:57 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	1,482,656	0	0	1,482,656	1,482,656	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	21,682	0	0	21,682	21,682	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	0.0154	0.0154	0.0154	0.0154		24.00
25.00	Disproportionate share adjustment (line 20 times line 24)	11.00	22,833	0	0	22,833	22,833	25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	12.00	1,527,171	0	0	1,527,171	1,527,171	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				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to W/S E Part A.		N					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140013	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/22/2014 7:57 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	10,020	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	11,838,895	2.00
3.00	PPS payments	9,086,832	3.00
4.00	Outlier payment (see instructions)	75,845	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.762	5.00
6.00	Line 2 times line 5	9,021,238	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)	10,020	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	42,347	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)	42,347	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 chargebasis 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)	42,347	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	32,327	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)	10,020	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)	9,162,677	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)	1,977,919	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)	7,194,778	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)	7,194,778	30.00
31.00	Primary payer payments	3,542	31.00
32.00	Subtotal (line 30 minus line 31)	7,191,236	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)	449,734	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	292,327	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	190,145	36.00
37.00	Subtotal (see instructions)	7,483,563	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-57	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)	7,483,620	40.00
40.01	Sequestration adjustment (see instructions)	113,003	40.01
41.00	Interim payments	7,215,659	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	154,958	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140013 Component CCN: 14S013	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/22/2014 7:57 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	168	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	174	2.00
3.00	PPS payments	454	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)	168	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	689	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)	689	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 chargebasis 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)	689	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	521	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)	168	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)	454	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)	74	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)	548	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)	548	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	548	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	548	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	548	40.00
40.01	Sequestration adjustment (see instructions)	8	40.01
41.00	Interim payments	522	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	18	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140013 Component CCN: 145579	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/22/2014 7:57 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	39	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		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)	39	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	159	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)	159	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 chargebasis 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)	159	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	120	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)	39	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		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)	39	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)	39	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	39	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	39	37.00
38.00	MSP-LCC reconciliation amount from PS&R		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)	39	40.00
40.01	Sequestration adjustment (see instructions)	1	40.01
41.00	Interim payments	36	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	2	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)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E-1 Part I | Date/Time Prepared: 5/22/2014 7:57 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		17,958,616		7,233,547	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	06/12/2013	27,330	06/12/2013	17,888	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)		-27,330		-17,888	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)		17,931,286		7,215,659	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		85,246		154,958	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		18,016,532		7,370,617	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E-1 Part I | Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,840,619		522	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)		1,840,619		522	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		2,331		18	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,842,950		540	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E-1 Part I | Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,211,804		36	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)		1,211,804		36	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		460		2	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,212,264		38	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: 140013	Period: From 01/01/2013 To 12/31/2013	Worksheet E-1 Part II Date/Time Prepared: 5/22/2014 7:57 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	5,419	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	12,578	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	2,801	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	21,707	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	358,959,246	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	2,049,393	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	2,033,760	8.00
9.00	Sequestration adjustment amount (see instructions)	40,675	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1,993,085	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	1,856,705	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)	136,380	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140013 Component CCN: 14S013	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part II Date/Time Prepared: 5/22/2014 7:57 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,984,207	1.00
2.00	Net IPF PPS Outlier Payments	16,598	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program". (see inst.)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program". (see inst.)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	8.380822	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2,000,805	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	15.00
16.00	Subtotal (see instructions)	2,000,805	16.00
17.00	Primary payer payments	248	17.00
18.00	Subtotal (line 16 less line 17).	2,000,557	18.00
19.00	Deductibles	124,320	19.00
20.00	Subtotal (line 18 minus line 19)	1,876,237	20.00
21.00	Coinsurance	5,032	21.00
22.00	Subtotal (line 20 minus line 21)	1,871,205	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,871,205	26.00
27.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,871,205	31.00
31.01	Sequestration adjustment (see instructions)	28,255	31.01
32.00	Interim payments	1,840,619	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33	2,331	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	16,598	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140013 Component CCN: 145579	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part VI Date/Time Prepared: 5/22/2014 7:57 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,259,710	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,259,710	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	28,860	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)	1,230,850	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14	1,230,850	15.00
15.01	Sequestration adjustment (see instructions)	18,586	15.01
16.00	Interim payments	1,211,804	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program line 15 minus 15.01, 16 and 17	460	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet G | Date/Time Prepared: 5/22/2014 7:57 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	4,185,560	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	12,213,306	0	0	0	4.00
5.00	Other receivable	4,896,825	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	3,498,104	0	0	0	7.00
8.00	Prepaid expenses	2,652,168	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	16,194,124	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	43,640,087	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	35,655,961	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	35,655,961	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,865,735	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	7,055,906	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,921,641	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	88,217,689	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	9,489,201	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	8,056,057	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	9,318,020	0	0	0	43.00
44.00	Other current liabilities	11,183,054	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	38,046,332	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	28,505,918	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	11,465,906	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	39,971,824	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	78,018,156	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	10,199,533				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)	10,199,533	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	88,217,689	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet G-1 | Date/Time Prepared: 5/22/2014 7:57 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		9,029,720		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,169,813				2.00
3.00	Total (sum of line 1 and line 2)		10,199,533		0		3.00
4.00	ROUNDING	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)		10,199,533		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)		10,199,533		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	ROUNDING		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: 140013 | Period: From 01/01/2013 To 12/31/2013 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/22/2014 7:57 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	33,936,182		33,936,182	1.00
2.00	SUBPROVIDER - IPF	5,139,120		5,139,120	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	2,855,791		2,855,791	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)	41,931,093		41,931,093	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	6,145,986		6,145,986	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)	6,145,986		6,145,986	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	48,077,079		48,077,079	17.00
18.00	Ancillary services	0	0	0	18.00
19.00	Outpatient services	0	0	0	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		1,161,382	1,161,382	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OPERATING ROOM	42,393,910	53,812,815	96,206,725	27.00
27.01	LABOR & DELIVERY ROOM	2,645,376	174,458	2,819,834	27.01
27.02	ANESTHESIA	7,564,161	6,899,974	14,464,135	27.02
27.03	RADIOLOGY	7,451,684	42,851,748	50,303,432	27.03
27.04	LAB	9,386,046	23,674,568	33,060,614	27.04
27.05	RESPIRATORY THERAPY	7,416,842	3,888,227	11,305,069	27.05
27.06	PHYSICAL THERAPY	6,330,712	3,993,679	10,324,391	27.06
27.07	EEG	19,226,652	23,669,730	42,896,382	27.07
27.08	MEDICAL SUPPLIES	0	0	0	27.08
27.09	DRUGS	15,745,113	7,921,943	23,667,056	27.09
27.10	CARDIAC REHABILITATION	664	273,236	273,900	27.10
27.11	CLINIC	868	5,967,544	5,968,412	27.11
27.12	EMERGENCY ROOM	5,891,896	16,613,445	22,505,341	27.12
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	172,131,003	190,902,749	363,033,752	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		110,888,331		29.00
30.00	ROUNDING	3,521			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)		3,521		36.00
37.00	PROPERTY TAXES	99,000			37.00
38.00	CHULD CARE REVENUE	479,709			38.00
39.00	PROVISION FOR DOUBTFUL	7,169,867			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		7,748,576		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		103,143,276		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 140013	Period: From 01/01/2013 To 12/31/2013	Worksheet G-3 Date/Time Prepared: 5/22/2014 7:57 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	363,033,752	1.00
2.00	Less contractual allowances and discounts on patients' accounts	275,701,420	2.00
3.00	Net patient revenues (line 1 minus line 2)	87,332,332	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	103,143,276	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-15,810,944	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	LACTATION-INPATIENT	0	24.00
24.01	DIETARY REV IP	0	24.01
24.02	DIETARY REV OP	0	24.02
24.03	NET ASSETS RELEASED FROM REST	0	24.03
24.05	NURSING ADMIN	0	24.05
24.06	DAYCARE CENTER	0	24.06
24.07	ROUND	1,369	24.07
24.08	OTHER OPERATING REVENUE	7,595,745	24.08
24.09	NON OPERATING INCOME	16,668,661	24.09
25.00	Total other income (sum of lines 6-24)	24,265,775	25.00
26.00	Total (line 5 plus line 25)	8,454,831	26.00
27.00	NONOPERATING LOSS	118,812	27.00
27.01	INTEREST	1,438,637	27.01
27.02	DEPRECIATION	5,727,569	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	7,285,018	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,169,813	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140013 | HHA CCN: 147049 | Period: From 01/01/2013 To 12/31/2013 | Worksheet H | Date/Time Prepared: 5/22/2014 7:57 pm

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	105,544	0	0	24,492	11,570	141,606	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	281,370	0	18,381	0	0	299,751	6.00
7.00	Physical Therapy	0	0	0	181,916	0	181,916	7.00
8.00	Occupational Therapy	0	0	0	37,026	0	37,026	8.00
9.00	Speech Pathology	0	0	0	1,870	0	1,870	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	7,218	7,218	12.00
13.00	Drugs	0	0	0	0	1,056	1,056	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	386,914	0	18,381	245,304	19,844	670,443	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	-1,129	140,477	0	140,477			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	299,751	0	299,751			6.00
7.00	Physical Therapy	0	181,916	0	181,916			7.00
8.00	Occupational Therapy	0	37,026	0	37,026			8.00
9.00	Speech Pathology	0	1,870	0	1,870			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	0	0	0			11.00
12.00	Supplies (see instructions)	0	7,218	0	7,218			12.00
13.00	Drugs	0	1,056	0	1,056			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	-1,129	669,314	0	669,314			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 140013 HHA CCN: 147049 | Period: From 01/01/2013 To 12/31/2013 | Worksheet H-1 Part I Date/Time Prepared: 5/22/2014 7:57 pm

Home Health Agency I | PPS

			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	140,477	0	0	0	0	140,477	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	299,751	0	0	0	0	299,751	6.00
7.00	Physical Therapy	181,916	0	0	0	0	181,916	7.00
8.00	Occupational Therapy	37,026	0	0	0	0	37,026	8.00
9.00	Speech Pathology	1,870	0	0	0	0	1,870	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	7,218	0	0	0	0	7,218	12.00
13.00	Drugs	1,056	0	0	0		1,056	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	669,314	0	0	0	0	669,314	24.00

		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	140,477						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	79,624	379,375					6.00
7.00	Physical Therapy	48,323	230,239					7.00
8.00	Occupational Therapy	9,835	46,861					8.00
9.00	Speech Pathology	497	2,367					9.00
10.00	Medical Social Services	0	0					10.00
11.00	Home Health Aide	0	0					11.00
12.00	Supplies (see instructions)	1,917	9,135					12.00
13.00	Drugs	281	1,337					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
24.00	Total (sum of lines 1-23)		669,314					24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 140013 | HHA CCN: 147049 | Period: From 01/01/2013 To 12/31/2013 | Worksheet H-1 Part II Date/Time Prepared: 5/22/2014 7:57 pm

Home Health Agency I | PPS

		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-140,477	528,837	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	299,751	6.00
7.00	Physical Therapy	0	0	0	0	0	181,916	7.00
8.00	Occupational Therapy	0	0	0	0	0	37,026	8.00
9.00	Speech Pathology	0	0	0	0	0	1,870	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	7,218	12.00
13.00	Drugs	0	0	0		0	1,056	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-140,477	528,837	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		140,477	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.265634	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140013 HHA CCN: 147049 | Period: From 01/01/2013 To 12/31/2013 | Worksheet H-2 Part I Date/Time Prepared: 5/22/2014 7:57 pm

Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	5,456	8,023	93,822	107,301	25,870	1.00
2.00	Skilled Nursing Care	379,375	0	0	0	379,375	91,467	2.00
3.00	Physical Therapy	230,239	0	0	0	230,239	55,510	3.00
4.00	Occupational Therapy	46,861	0	0	0	46,861	11,298	4.00
5.00	Speech Pathology	2,367	0	0	0	2,367	571	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	9,135	0	0	0	9,135	2,202	8.00
9.00	Drugs	1,337	0	0	0	1,337	322	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	669,314	5,456	8,023	93,822	776,615	187,240	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	8,205	7,191	0	5,739	0	23,400	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	8,205	7,191	0	5,739	0	23,400	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140013 | HHA CCN: 147049 | Period: From 01/01/2013 To 12/31/2013 | Worksheet H-2 Part I | Date/Time Prepared: 5/22/2014 7:57 pm

Home Health Agency I | PPS

	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
		13.00	14.00	15.00	16.00	17.00	24.00	
1.00	Administrative and General	34,698	435	876	13,469	0	227,184	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	470,842	2.00
3.00	Physical Therapy	0	0	0	0	0	285,749	3.00
4.00	Occupational Therapy	0	0	0	0	0	58,159	4.00
5.00	Speech Pathology	0	0	0	0	0	2,938	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	11,337	8.00
9.00	Drugs	0	0	0	0	0	1,659	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	34,698	435	876	13,469	0	1,057,868	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	227,184					1.00
2.00	Skilled Nursing Care	0	470,842	128,770	599,612			2.00
3.00	Physical Therapy	0	285,749	78,149	363,898			3.00
4.00	Occupational Therapy	0	58,159	15,906	74,065			4.00
5.00	Speech Pathology	0	2,938	804	3,742			5.00
6.00	Medical Social Services	0	0	0	0			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	11,337	3,101	14,438			8.00
9.00	Drugs	0	1,659	454	2,113			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
20.00	Total (sum of lines 1-19) (2)	0	1,057,868	227,184	1,057,868			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.273490				21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140013 HHA CCN: 147049 | Period: From 01/01/2013 To 12/31/2013 | Worksheet H-2 Part II Date/Time Prepared: 5/22/2014 7:57 pm

Home Health Agency I | PPS

	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	760	760	386,914	0	107,301	760	1.00
2.00	Skilled Nursing Care	0	0	0	0	379,375	0	2.00
3.00	Physical Therapy	0	0	0	0	230,239	0	3.00
4.00	Occupational Therapy	0	0	0	0	46,861	0	4.00
5.00	Speech Pathology	0	0	0	0	2,367	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	9,135	0	8.00
9.00	Drugs	0	0	0	0	1,337	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	760	760	386,914		776,615	760	20.00
21.00	Total cost to be allocated	5,456	8,023	93,822		187,240	8,205	21.00
22.00	Unit cost multiplier	7.178947	10.556579	0.242488		0.241098	10.796053	22.00

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (GROSS SALARIE)	NURSING ADMINISTRATION (NURSING SALARIE)	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	760	0	760	0	386,914	386,914	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	760	0	760	0	386,914	386,914	20.00
21.00	Total cost to be allocated	7,191	0	5,739	0	23,400	34,698	21.00
22.00	Unit cost multiplier	9.461842	0.000000	7.551316	0.000000	0.060479	0.089679	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140013 HHA CCN: 147049 | Period: From 01/01/2013 To 12/31/2013 | Worksheet H-2 Part II Date/Time Prepared: 5/22/2014 7:57 pm

Home Health Agency I | PPS

	Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)			
		14.00	15.00	16.00	17.00			
1.00	Administrative and General	7,218	1,056	1,161,382	0			1.00
2.00	Skilled Nursing Care	0	0	0	0			2.00
3.00	Physical Therapy	0	0	0	0			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	0	0	0			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
20.00	Total (sum of lines 1-19)	7,218	1,056	1,161,382	0			20.00
21.00	Total cost to be allocated	435	876	13,469	0			21.00
22.00	Unit cost multiplier	0.060266	0.829545	0.011597	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 140013 | HHA CCN: 147049 | Period: From 01/01/2013 To 12/31/2013 | Worksheet H-3 Part I | Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	599,612		599,612	2,337	256.57	1.00
2.00	Physical Therapy	3.00	363,898	0	363,898	2,432	149.63	2.00
3.00	Occupational Therapy	4.00	74,065	0	74,065	495	149.63	3.00
4.00	Speech Pathology	5.00	3,742	0	3,742	25	149.68	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	0		0	0	0.00	6.00
7.00	Total (sum of lines 1-6)		1,041,317	0	1,041,317	5,289		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		37900	965	347			8.00
8.01	Skilled Nursing Care		99914	2	0			8.01
8.02	Skilled Nursing Care		99919	0	2			8.02
8.03	Skilled Nursing Care		99926	2	0			8.03
9.00	Physical Therapy		37900	998	429			9.00
9.01	Physical Therapy		99914	6	0			9.01
9.02	Physical Therapy		99919	0	1			9.02
9.03	Physical Therapy		99926	10	0			9.03
10.00	Occupational Therapy		37900	162	112			10.00
10.01	Occupational Therapy		99914	0	0			10.01
10.02	Occupational Therapy		99919	0	0			10.02
10.03	Occupational Therapy		99926	0	0			10.03
11.00	Speech Pathology		37900	3	10			11.00
11.01	Speech Pathology		99914	0	0			11.01
11.02	Speech Pathology		99919	0	0			11.02
11.03	Speech Pathology		99926	0	0			11.03
12.00	Medical Social Services		37900	0	0			12.00
12.01	Medical Social Services		99914	0	0			12.01
12.02	Medical Social Services		99919	0	0			12.02
12.03	Medical Social Services		99926	0	0			12.03
13.00	Home Health Aide		37900	0	0			13.00
13.01	Home Health Aide		99914	0	0			13.01
13.02	Home Health Aide		99919	0	0			13.02
13.03	Home Health Aide		99926	0	0			13.03
14.00	Total (sum of lines 8-13)			2,148	901			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	14,438	0	14,438	3,708	3.893743	15.00
16.00	Cost of Drugs	9.00	2,113	0	2,113	0	0.000000	16.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140013 | HHA CCN: 147049 | Period: From 01/01/2013 To 12/31/2013 | Worksheet H-3 Part I | Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	969	349		248,616	89,543		1.00
2.00	Physical Therapy	1,014	430		151,725	64,341		2.00
3.00	Occupational Therapy	162	112		24,240	16,759		3.00
4.00	Speech Pathology	3	10		449	1,497		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	0		0	0		6.00
7.00	Total (sum of lines 1-6)	2,148	901		425,030	172,140		7.00
	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
8.03	Skilled Nursing Care							8.03
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
9.03	Physical Therapy							9.03
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
10.03	Occupational Therapy							10.03
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
11.03	Speech Pathology							11.03
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
12.03	Medical Social Services							12.03
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
13.03	Home Health Aide							13.03
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges: Part A	Program Covered Charges: Part B Not Subject to Deductibles & Coinsurance	Program Covered Charges: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies							15.00
16.00	Cost of Drugs		0	0		0	0	16.00

APPORTIONMENT OF PATIENT SERVICE COSTS	Provider CCN: 140013 HHA CCN: 147049	Period: From 01/01/2013 To 12/31/2013	Worksheet H-3 Part I Date/Time Prepared: 5/22/2014 7:57 pm
	Title XVIII	Home Health Agency I	PPS

	Cost Center Description	Total Program Cost (sum of cols. 9-10)		
		12.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION			
	Cost Per Visit Computation			
1.00	Skilled Nursing Care	338,159		1.00
2.00	Physical Therapy	216,066		2.00
3.00	Occupational Therapy	40,999		3.00
4.00	Speech Pathology	1,946		4.00
5.00	Medical Social Services	0		5.00
6.00	Home Health Aide	0		6.00
7.00	Total (sum of lines 1-6)	597,170		7.00

	Cost Center Description			
		12.00		
	Limitation Cost Computation			
8.00	Skilled Nursing Care			8.00
8.01	Skilled Nursing Care			8.01
8.02	Skilled Nursing Care			8.02
8.03	Skilled Nursing Care			8.03
9.00	Physical Therapy			9.00
9.01	Physical Therapy			9.01
9.02	Physical Therapy			9.02
9.03	Physical Therapy			9.03
10.00	Occupational Therapy			10.00
10.01	Occupational Therapy			10.01
10.02	Occupational Therapy			10.02
10.03	Occupational Therapy			10.03
11.00	Speech Pathology			11.00
11.01	Speech Pathology			11.01
11.02	Speech Pathology			11.02
11.03	Speech Pathology			11.03
12.00	Medical Social Services			12.00
12.01	Medical Social Services			12.01
12.02	Medical Social Services			12.02
12.03	Medical Social Services			12.03
13.00	Home Health Aide			13.00
13.01	Home Health Aide			13.01
13.02	Home Health Aide			13.02
13.03	Home Health Aide			13.03
14.00	Total (sum of lines 8-13)			14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140013 | HHA CCN: 147049 | Period: From 01/01/2013 To 12/31/2013 | Worksheet H-3 Part II | Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
		0	1.00	2.00	3.00	4.00	
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.266998	0	0	col. 2, line 2.00	1.00
2.00	Occupational Therapy						2.00
3.00	Speech Pathology						3.00
4.00	Cost of Medical Supplies	71.00	0.479026	0	0	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.246984	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 140013 | HHA CCN: 147049 | Period: From 01/01/2013 To 12/31/2013 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/22/2014 7:57 pm

Title XVIII | Home Health Agency I | PPS

		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount 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(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	370,958	166,812	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	11,347	1,611	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	13,432	7,337	13.00
14.00	Total PPS Reimbursement - PEP Episodes	5,881	1,422	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	4,351	262	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	530	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	406,499	177,444	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	406,499	177,444	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	406,499	177,444	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	406,499	177,444	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	406,499	177,444	31.00
31.01	Sequestration adjustment (see instructions)	5,386	2,802	31.01
32.00	Interim payments (see instructions)	401,114	174,642	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33	-1	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 140013 HHA CCN: 147049 | Period: From 01/01/2013 To 12/31/2013 | Worksheet H-5 | Date/Time Prepared: 5/22/2014 7:57 pm

Home Health Agency I | 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		401,114		174,642	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			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			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. H-4, Part II, column as appropriate, line 32)		401,114		174,642	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		1		0	6.02
7.00	Total Medicare program liability (see instructions)		401,113		174,642	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140013	Period: From 01/01/2013 To 12/31/2013	Worksheet L Parts I-III Date/Time Prepared: 5/22/2014 7:57 pm
	Title XVIII	Hospital	PPS

			1.00	
	PART I - FULLY PROSPECTIVE METHOD			
	CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier		1,482,656	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		21,682	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)		59.76	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)		2.73	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		4.81	8.00
9.00	Sum of lines 7 and 8		7.54	9.00
10.00	Allowable disproportionate share percentage (see instructions)		1.54	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		22,833	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		1,527,171	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