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: 140160	Period: From 01/01/2013 To 12/31/2013	Worksheet S Parts I-III Date/Time Prepared: 5/22/2014 4:37 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/22/2014 Time: 4:37 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 FHN MEMORIAL HOSPITAL (140160) 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	-326,917	47,555	7,945	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-326,917	47,555	7,945	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I | Date/Time Prepared: 5/22/2014 2:03 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1405 WEST STEPHENSON STREET	PO Box:			1.00
2.00	City: FREEPORT	State: IL	Zip Code: 64032	County: STEPHENSON	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	FHN MEMORIAL HOSPITAL	140160	99914	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	FHN MEMORIAL - HOSPICE	141560	99914		08/12/1993				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.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	Y	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.	1	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.	2,238	281	13	4	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.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 5/22/2014 2:03 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.	1		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.	01/01/2013	12/31/2013	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	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
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: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I | Date/Time Prepared: 5/22/2014 2:03 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: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I | Date/Time Prepared: 5/22/2014 2:03 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.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	71.00
	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)	N		106.00

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		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)			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.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	1,935,268	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	Y	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.	N		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

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	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)	0.75	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2012	09/30/2013	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part II Date/Time Prepared: 5/22/2014 2:03 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		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.	Y	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	04/24/2014	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part II Date/Time Prepared: 5/22/2014 2:03 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.	DAN	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: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part II | Date/Time Prepared: 5/22/2014 2:03 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)	04/24/2014			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		MANAGER		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: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part I Date/Time Prepared: 5/22/2014 2:03 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	92	33,580	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)		92	33,580	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	8	2,920	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)		100	36,500	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			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)		100				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: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part I | Date/Time Prepared: 5/22/2014 2:03 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)	7,396	1,817	13,920			1.00
2.00	HMO and other (see instructions)	2,266	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)	7,396	1,817	13,920			7.00
8.00	INTENSIVE CARE UNIT	865	160	1,547			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		559	767			13.00
14.00	Total (see instructions)	8,261	2,536	16,234	0.00	503.88	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	17.93	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	521.81	27.00
28.00	Observation Bed Days		0	3,289			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	120			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: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part I | Date/Time Prepared: 5/22/2014 2:03 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	2,089	691	4,303	1.00
2.00	HMO and other (see instructions)			569			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	2,089	691	4,303	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					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: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part II Date/Time Prepared: 5/22/2014 2:03 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	29,935,763	0	29,935,763	1,072,527.50	27.91	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		772,577	0	772,577	5,695.80	135.64	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		877,474	33,885	911,359	38,226.60	23.84	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		436,264	0	436,264	8,151.50	53.52	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		19,515	0	19,515	365.00	53.47	13.00
14.00	Home office salaries & wage-related costs		4,353,997	0	4,353,997	124,803.00	34.89	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)		9,406,089	0	9,406,089			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		361,904	0	361,904			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	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	2,203,954	-22,248	2,181,706	96,896.70	22.52	27.00
28.00	Administrative & General under contract (see inst.)		40,900	0	40,900	146.70	278.80	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	242,387	0	242,387	15,476.20	15.66	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,773,997	0	1,773,997	90,453.00	19.61	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		1,941,602	0	1,941,602	72,605.00	26.74	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	603,529	0	603,529	15,876.90	38.01	38.00
39.00	Central Services and Supply	14.00	83,539	0	83,539	6,592.50	12.67	39.00
40.00	Pharmacy	15.00	1,154,435	0	1,154,435	34,347.70	33.61	40.00
41.00	Medical Records & Medical Records Library	16.00	1,041,023	0	1,041,023	43,717.30	23.81	41.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part II Date/Time Prepared: 5/22/2014 2:03 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	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part III Date/Time Prepared: 5/22/2014 2:03 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)		32,919,685	0	32,919,685	1,230,036.40	26.76	1.00
2.00	Excluded area salaries (see instructions)		877,474	33,885	911,359	38,226.60	23.84	2.00
3.00	Subtotal salaries (line 1 minus line 2)		32,042,211	-33,885	32,008,326	1,191,809.80	26.86	3.00
4.00	Subtotal other wages & related costs (see inst.)		4,809,776	0	4,809,776	133,319.50	36.08	4.00
5.00	Subtotal wage-related costs (see inst.)		9,406,089	0	9,406,089	0.00	29.39	5.00
6.00	Total (sum of lines 3 thru 5)		46,258,076	-33,885	46,224,191	1,325,129.30	34.88	6.00
7.00	Total overhead cost (see instructions)		9,085,366	-22,248	9,063,118	376,112.00	24.10	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part IV Date/Time Prepared: 5/22/2014 2:03 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	628,167	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)	6,242,078	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	171,587	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	12,955	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)	82,648	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	175,808	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	2,122,740	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	52,066	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	9,488,049	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: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part V Date/Time Prepared: 5/22/2014 2:03 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	436,264	0	1.00
2.00	Hospital	436,264	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	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

HOSPITAL IDENTIFICATION DATA	Provider CCN: 140160 Component CCN: 141560	Period: From 01/01/2013 To 12/31/2013	Worksheet S-9 Parts I & II Date/Time Prepared: 5/22/2014 2:03 pm
		Hospice I	

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Routine Home Care	12,741	523	0	0	542	13,806	2.00
3.00	Inpatient Respite Care	18	0	0	0	0	18	3.00
4.00	General Inpatient Care	25	0	0	0	0	25	4.00
5.00	Total Hospice Days	12,784	523	0	0	542	13,849	5.00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving Hospice Care	267	10	0	0	20	297	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00				7.00
8.00	Average Length of Stay (line 5/line 6)	47.88	52.30	0.00	0.00	27.10	46.63	8.00
9.00	Unduplicated Census Count	267	10	0	0	20	297	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-10 | Date/Time Prepared: 5/22/2014 2:03 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)	0.251528	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,747,218	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	3,494,420	5.00
6.00	Medicaid charges	51,772,674	6.00
7.00	Medicaid cost (line 1 times line 6)	13,022,277	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)	4,780,639	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	30,031	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	4,780,639	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	6,527,429	397,527	6,924,956	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,641,831	99,989	1,741,820	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)	1,641,831	99,989	1,741,820	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)	12,955,481	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	506,777	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	12,448,704	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	3,131,198	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,873,018	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	9,653,657	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A | Date/Time Prepared: 5/22/2014 2:03 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		0	0	1,800,492	1,800,492	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,700,354	3,700,354	-1,800,492	1,899,862	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,493,502	9,493,502	0	9,493,502	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,203,954	18,692,790	20,896,744	-28,580	20,868,164	5.00
7.00	00700	OPERATION OF PLANT	242,387	2,999,648	3,242,035	0	3,242,035	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	468,145	468,145	0	468,145	8.00
9.00	00900	HOUSEKEEPING	0	1,886,220	1,886,220	0	1,886,220	9.00
10.00	01000	DIETARY	0	2,652,432	2,652,432	-1,327,995	1,324,437	10.00
11.00	01100	CAFETERIA	0	0	0	1,327,995	1,327,995	11.00
13.00	01300	NURSING ADMINISTRATION	603,529	33,960	637,489	0	637,489	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	83,539	1,198,426	1,281,965	-412,291	869,674	14.00
15.00	01500	PHARMACY	1,154,435	3,515,561	4,669,996	-2,901,888	1,768,108	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,041,023	682,106	1,723,129	0	1,723,129	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,346,841	1,842,906	10,189,747	-12,298	10,177,449	30.00
31.00	03100	INTENSIVE CARE UNIT	1,400,003	356,487	1,756,490	0	1,756,490	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,589,579	5,065,929	6,655,508	0	6,655,508	50.00
50.01	05001	GI LAB	965,148	746,637	1,711,785	0	1,711,785	50.01
50.02	05002	AMBULATORY CARE UNIT	1,000,173	148,618	1,148,791	0	1,148,791	50.02
51.00	05100	RECOVERY ROOM	525,131	16,806	541,937	0	541,937	51.00
53.00	05300	ANESTHESIOLOGY	0	483,970	483,970	0	483,970	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,973,566	4,900,896	6,874,462	0	6,874,462	54.00
60.00	06000	LABORATORY	1,370,842	2,940,673	4,311,515	0	4,311,515	60.00
65.00	06500	RESPIRATORY THERAPY	730,011	255,097	985,108	0	985,108	65.00
66.00	06600	PHYSICAL THERAPY	2,113,702	210,885	2,324,587	0	2,324,587	66.00
69.00	06900	ELECTROCARDIOLOGY	164,221	104,504	268,725	0	268,725	69.00
69.01	06901	CATH LAB	437,826	1,434,550	1,872,376	0	1,872,376	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	97,407	14,326	111,733	0	111,733	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	412,291	412,291	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	2,901,888	2,901,888	73.00
76.00	03020	DIABETIC EDUCATION	164	124,372	124,536	0	124,536	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	822,254	822,254	0	822,254	90.00
91.00	09100	EMERGENCY	3,014,808	5,603,013	8,617,821	0	8,617,821	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
116.00	11600	HOSPICE	866,751	758,407	1,625,158	0	1,625,158	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,925,040	71,153,474	101,078,514	-40,878	101,037,636	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,723	77,447	88,170	0	88,170	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	0	0	0	28,580	28,580	192.03
192.04	19204	SMART STEPS	0	0	0	0	0	192.04
192.05	19205	RESPITE CARE	0	0	0	12,298	12,298	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118-199)	29,935,763	71,230,921	101,166,684	0	101,166,684	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A | Date/Time Prepared: 5/22/2014 2:03 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	0	1,800,492		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-1,052	1,898,810		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,493,502		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,335,167	19,532,997		5.00
7.00	00700	OPERATION OF PLANT	0	3,242,035		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	468,145		8.00
9.00	00900	HOUSEKEEPING	0	1,886,220		9.00
10.00	01000	DIETARY	-481,961	842,476		10.00
11.00	01100	CAFETERIA	-5,915	1,322,080		11.00
13.00	01300	NURSING ADMINISTRATION	-9,155	628,334		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	869,674		14.00
15.00	01500	PHARMACY	-12,007	1,756,101		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-35,524	1,687,605		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,927,909	8,249,540		30.00
31.00	03100	INTENSIVE CARE UNIT	-290,500	1,465,990		31.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	6,655,508		50.00
50.01	05001	GI LAB	0	1,711,785		50.01
50.02	05002	AMBULATORY CARE UNIT	0	1,148,791		50.02
51.00	05100	RECOVERY ROOM	0	541,937		51.00
53.00	05300	ANESTHESIOLOGY	-326,172	157,798		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,334,707	4,539,755		54.00
60.00	06000	LABORATORY	-499,425	3,812,090		60.00
65.00	06500	RESPIRATORY THERAPY	-59,401	925,707		65.00
66.00	06600	PHYSICAL THERAPY	-8,901	2,315,686		66.00
69.00	06900	ELECTROCARDIOLOGY	-91,186	177,539		69.00
69.01	06901	CATH LAB	-39,000	1,833,376		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	111,733		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	412,291		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,901,888		73.00
76.00	03020	DIABETIC EDUCATION	-3,248	121,288		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	822,254		90.00
91.00	09100	EMERGENCY	-5,079,979	3,537,842		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	-10,000	1,615,158		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-12,551,209	88,486,427		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	88,170		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	JANE ADDAMS BLDG	0	0		192.01
192.02	19202	SENIOR PROGRAM	0	0		192.02
192.03	19203	NA VOLUNTEER SERVICES	0	28,580		192.03
192.04	19204	SMART STEPS	0	0		192.04
192.05	19205	RESPITE CARE	0	12,298		192.05
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118-199)	-12,551,209	88,615,475		200.00

RECLASSIFICATIONS | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-6 | Date/Time Prepared: 5/22/2014 2:03 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CHARGEABLE SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	412,291	1.00
	TOTALS		0	412,291	
	B - CHARGEABLE DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,901,888	1.00
	TOTALS		0	2,901,888	
	C - SHARED DIETARY EXPENSES				
1.00	CAFETERIA	11.00	0	1,327,995	1.00
	TOTALS		0	1,327,995	
	D - RESPITE CARE (B)				
1.00	RESPITE CARE	192.05	11,637	661	1.00
	TOTALS		11,637	661	
	E - NON PATIENT VOLUNTEER ADMIN				
1.00	NA VOLUNTEER SERVICES	192.03	22,248	6,332	1.00
	TOTALS		22,248	6,332	
	G - BUILDING DEPRECIATION				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,800,492	1.00
	TOTALS		0	1,800,492	
500.00	Grand Total: Increases		33,885	6,449,659	500.00

RECLASSIFICATIONS | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-6 | Date/Time Prepared: 5/22/2014 2:03 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CHARGEABLE SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	412,291	0	1.00
	TOTALS		0	412,291		
	B - CHARGEABLE DRUGS					
1.00	PHARMACY	15.00	0	2,901,888	0	1.00
	TOTALS		0	2,901,888		
	C - SHARED DIETARY EXPENSES					
1.00	DIETARY	10.00	0	1,327,995	0	1.00
	TOTALS		0	1,327,995		
	D - RESPITE CARE (B)					
1.00	ADULTS & PEDIATRICS	30.00	11,637	661	0	1.00
	TOTALS		11,637	661		
	E - NON PATIENT VOLUNTEER ADMIN					
1.00	ADMINISTRATIVE & GENERAL	5.00	22,248	6,332	0	1.00
	TOTALS		22,248	6,332		
	G - BUILDING DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,800,492	9	1.00
	TOTALS		0	1,800,492		
500.00	Grand Total: Decreases		33,885	6,449,659		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-7 Part I | Date/Time Prepared: 5/22/2014 2:03 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	944,945	0	0	0	0	1.00
2.00	Land Improvements	1,797,684	0	0	0	0	2.00
3.00	Buildings and Fixtures	47,818,829	348,611	0	348,611	204,298	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	1,330,609	21,428	0	21,428	0	5.00
6.00	Movable Equipment	22,880,645	1,237,226	0	1,237,226	420,753	6.00
7.00	HIT designated Assets	2,827,887	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	77,600,599	1,607,265	0	1,607,265	625,051	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	77,600,599	1,607,265	0	1,607,265	625,051	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	944,945	0	1.00
2.00	Land Improvements	1,797,684	0	2.00
3.00	Buildings and Fixtures	47,963,142	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	1,352,037	0	5.00
6.00	Movable Equipment	23,697,118	0	6.00
7.00	HIT designated Assets	2,827,887	0	7.00
8.00	Subtotal (sum of lines 1-7)	78,582,813	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	78,582,813	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-7 Part II | Date/Time Prepared: 5/22/2014 2:03 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	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,700,354	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,700,354	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	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,700,354		2.00
3.00	Total (sum of lines 1-2)	0	3,700,354		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-7 Part III Date/Time Prepared: 5/22/2014 2:03 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	54,885,694	0	54,885,694	0.698444	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	23,697,119	0	23,697,119	0.301556	0	2.00
3.00	Total (sum of lines 1-2)	78,582,813	0	78,582,813	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	1,800,492	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,898,810	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,699,302	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	0	0	0	0	1,800,492	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,898,810	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	3,699,302	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-8 | Date/Time Prepared: 5/22/2014 2:03 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	-10,663,339			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	-1,161,848			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	TRADE, QUANTITY AND TIME DISCOUNTS	B	-8,824	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-8 | Date/Time Prepared: 5/22/2014 2:03 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	
33.01	CAFETERIA--EMPLOYEES AND GUESTS	B	-467,415	DIETARY	10.00	0	33.01
33.02	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-12,007	PHARMACY	15.00	0	33.02
33.03	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-35,524	MEDICAL RECORDS & LIBRARY	16.00	0	33.03
33.04	VENDING MACHINES	B	-5,915	CAFETERIA	11.00	0	33.04
33.05	DIETARY REVENUE	B	-74	DIETARY	10.00	0	33.05
33.06	PHYSICIAN COLLECTIONS EXPENSES	A	-72,958	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	DIETARY CONSULTING	B	-170	DIETARY	10.00	0	33.07
33.08	TELEPHONE CAPITAL COSTS	A	-10,831	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	TV CAPITAL COSTS	A	-8,526	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	ASSOC LOBBYING FEES	A	-46,896	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	MEALS ON WHEELS	B	-14,302	DIETARY	10.00	0	33.11
33.12	HBP HOSPICE	A	-10,000	HOSPICE	116.00	0	33.12
33.13	OTHER REVENUE MISC	B	-442	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	OB MISC INCOME	B	-134	ADULTS & PEDIATRICS	30.00	0	33.14
33.15	LIFELINE EXPENSE	A	-15,245	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	OP FINANCE MISC INCOME	B	-9,513	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.19	LIFELINE DEPRE	A	-1,052	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.19
33.20	NONPATIENT DIABETIC REVENUE	B	-3,248	DIABETIC EDUCATION	76.00	0	33.20
33.22	RADIOLOGY MED RECORD REVENUE	B	-45	RADIOLOGY-DIAGNOSTIC	54.00	0	33.22
33.24	SPORTS MEDICINE MISC INCOME	B	-2,901	PHYSICAL THERAPY	66.00	0	33.24
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-12,551,209				50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-8-1 | Date/Time Prepared: 5/22/2014 2:03 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	CORPORATE ALLOCATION	8,823,559	9,985,407	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	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			8,823,559	9,985,407	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:					

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	A	FREEPORT MEMORI	100.00	FREEPORT HEALTH	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 140160	Period: From 01/01/2013 To 12/31/2013	Worksheet A-8-1 Date/Time Prepared: 5/22/2014 2:03 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	-1,161,848	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-1,161,848			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 CARE PARENT CO		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: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-8-2 | Date/Time Prepared: 5/22/2014 2:03 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	1,155,198	1,155,198	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	290,500	290,500	0	0	0	2.00
3.00	13.00	NURSING ADMINISTRATION	9,155	9,155	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	326,172	326,172	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	2,334,662	2,334,662	0	0	0	5.00
6.00	60.00	LABORATORY	499,425	499,425	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	59,401	59,401	0	0	0	7.00
8.00	66.00	PHYSICAL THERAPY	6,000	6,000	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	91,186	91,186	0	0	0	9.00
10.00	69.01	CATH LAB	39,000	39,000	0	0	0	10.00
11.00	91.00	EMERGENCY	5,079,979	5,079,979	0	0	0	11.00
12.00	30.00	ADULTS & PEDIATRICS	772,577	772,577	0	0	0	12.00
13.00	5.00	ADMINISTRATIVE & GENERAL	19,599	84	19,515	365	159,800	13.00
200.00			10,682,854	10,663,339	19,515		159,800	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	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	9.00
10.00	69.01	CATH LAB	0	0	0	0	0	10.00
11.00	91.00	EMERGENCY	0	0	0	0	0	11.00
12.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	12.00
13.00	5.00	ADMINISTRATIVE & GENERAL	28,042	1,402	0	0	0	13.00
200.00			28,042	1,402	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	1,155,198		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	290,500		2.00
3.00	13.00	NURSING ADMINISTRATION	0	0	0	9,155		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	326,172		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	2,334,662		5.00
6.00	60.00	LABORATORY	0	0	0	499,425		6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	59,401		7.00
8.00	66.00	PHYSICAL THERAPY	0	0	0	6,000		8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	91,186		9.00
10.00	69.01	CATH LAB	0	0	0	39,000		10.00
11.00	91.00	EMERGENCY	0	0	0	5,079,979		11.00
12.00	30.00	ADULTS & PEDIATRICS	0	0	0	772,577		12.00
13.00	5.00	ADMINISTRATIVE & GENERAL	0	28,042	0	84		13.00
200.00			0	28,042	0	10,663,339		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part I | Date/Time Prepared: 5/22/2014 2:03 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,800,492	1,800,492				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,898,810		1,898,810			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,493,502	11,516	200	9,505,218		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,532,997	390,089	29,273	692,735	20,645,094	5.00
7.00	00700	OPERATION OF PLANT	3,242,035	206,874	21,956	76,963	3,547,828	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	468,145	13,861	0	0	482,006	8.00
9.00	00900	HOUSEKEEPING	1,886,220	30,410	6,366	0	1,922,996	9.00
10.00	01000	DIETARY	842,476	68,451	19,440	0	930,367	10.00
11.00	01100	CAFETERIA	1,322,080	58,420	0	0	1,380,500	11.00
13.00	01300	NURSING ADMINISTRATION	628,334	2,210	30,193	191,633	852,370	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	869,674	5,285	0	26,525	901,484	14.00
15.00	01500	PHARMACY	1,756,101	14,370	28,032	366,556	2,165,059	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,687,605	25,898	8,726	330,546	2,052,775	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,249,540	337,170	234,488	2,646,606	11,467,804	30.00
31.00	03100	INTENSIVE CARE UNIT	1,465,990	25,548	109,340	444,529	2,045,407	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,655,508	128,068	249,515	504,723	7,537,814	50.00
50.01	05001	GI LAB	1,711,785	41,312	64,667	306,454	2,124,218	50.01
50.02	05002	AMBULATORY CARE UNIT	1,148,791	55,511	25,037	317,575	1,546,914	50.02
51.00	05100	RECOVERY ROOM	541,937	9,877	520	166,740	719,074	51.00
53.00	05300	ANESTHESIOLOGY	157,798	5,095	155,679	0	318,572	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,539,755	103,587	425,324	626,647	5,695,313	54.00
60.00	06000	LABORATORY	3,812,090	52,466	85,395	435,270	4,385,221	60.00
65.00	06500	RESPIRATORY THERAPY	925,707	43,105	44,887	231,793	1,245,492	65.00
66.00	06600	PHYSICAL THERAPY	2,315,686	67,180	71,489	671,143	3,125,498	66.00
69.00	06900	ELECTROCARDIOLOGY	177,539	3,880	16,585	52,143	250,147	69.00
69.01	06901	CATH LAB	1,833,376	3,683	14,454	139,019	1,990,532	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	111,733	7,188	13,729	30,929	163,579	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	412,291	0	0	0	412,291	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,901,888	0	0	0	2,901,888	73.00
76.00	03020	DIABETIC EDUCATION	121,288	2,492	0	52	123,832	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	822,254	0	0	0	822,254	90.00
91.00	09100	EMERGENCY	3,537,842	81,114	239,683	957,262	4,815,901	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,615,158	0	3,832	275,211	1,894,201	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	88,486,427	1,794,660	1,898,810	9,491,054	88,466,431	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	88,170	4,696	0	3,405	96,271	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,136	0	0	1,136	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	28,580	0	0	7,064	35,644	192.03
192.04	19204	SMART STEPS	0	0	0	0	0	192.04
192.05	19205	RESPITE CARE	12,298	0	0	3,695	15,993	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	88,615,475	1,800,492	1,898,810	9,505,218	88,615,475	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part I | Date/Time Prepared: 5/22/2014 2:03 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	20,645,094					5.00
7.00	00700	OPERATION OF PLANT	1,077,607	4,625,435				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	146,403	53,785	682,194			8.00
9.00	00900	HOUSEKEEPING	584,085	118,002	0	2,625,083		9.00
10.00	01000	DIETARY	282,587	265,612	0	156,558	1,635,124	10.00
11.00	01100	CAFETERIA	419,309	226,691	0	133,617	0	11.00
13.00	01300	NURSING ADMINISTRATION	258,896	8,575	0	5,054	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	273,814	20,509	0	12,088	0	14.00
15.00	01500	PHARMACY	657,609	55,762	0	32,867	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	623,504	100,495	0	59,234	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,483,171	1,308,339	272,422	771,168	1,540,332	30.00
31.00	03100	INTENSIVE CARE UNIT	621,266	99,137	35,907	58,434	94,792	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,289,513	496,949	48,897	292,913	0	50.00
50.01	05001	GI LAB	645,204	160,306	55,617	94,488	0	50.01
50.02	05002	AMBULATORY CARE UNIT	469,855	215,401	27,328	126,962	0	50.02
51.00	05100	RECOVERY ROOM	218,409	38,326	15,544	22,590	0	51.00
53.00	05300	ANESTHESIOLOGY	96,762	19,770	0	11,653	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,729,877	401,956	65,510	236,922	0	54.00
60.00	06000	LABORATORY	1,331,954	203,586	4	119,998	0	60.00
65.00	06500	RESPIRATORY THERAPY	378,302	167,261	0	98,588	0	65.00
66.00	06600	PHYSICAL THERAPY	949,329	260,682	16,737	153,652	0	66.00
69.00	06900	ELECTROCARDIOLOGY	75,979	15,054	0	8,873	0	69.00
69.01	06901	CATH LAB	604,598	14,292	12,898	8,424	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	49,685	27,893	409	16,441	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	125,228	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	881,411	0	0	0	0	73.00
76.00	03020	DIABETIC EDUCATION	37,612	9,671	0	5,700	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	249,749	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,462,767	314,752	130,921	185,522	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	575,339	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,599,824	4,602,806	682,194	2,611,746	1,635,124	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	29,241	18,222	0	10,740	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	345	4,407	0	2,597	0	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	10,826	0	0	0	0	192.03
192.04	19204	SMART STEPS	0	0	0	0	0	192.04
192.05	19205	RESPITE CARE	4,858	0	0	0	0	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	20,645,094	4,625,435	682,194	2,625,083	1,635,124	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part I | Date/Time Prepared: 5/22/2014 2:03 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			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
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	2,160,117					11.00
13.00	01300	NURSING ADMINISTRATION	40,257	1,165,152				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	15,815	0	1,223,710			14.00
15.00	01500	PHARMACY	84,252	0	2,644	2,998,193		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	107,140	0	0	0	2,943,148	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	699,144	784,987	123,448	3,495	183,368	30.00
31.00	03100	INTENSIVE CARE UNIT	90,405	103,181	18,480	732	28,790	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	144,407	0	52,303	269,120	454,909	50.00
50.01	05001	GI LAB	80,111	0	118,816	3,154	168,714	50.01
50.02	05002	AMBULATORY CARE UNIT	74,245	0	7,941	3,098	10,886	50.02
51.00	05100	RECOVERY ROOM	29,790	0	2,945	0	18,755	51.00
53.00	05300	ANESTHESIOLOGY	0	0	38,211	44,929	59,082	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	197,085	0	86,756	22,279	584,794	54.00
60.00	06000	LABORATORY	144,061	0	95,470	3,114	351,531	60.00
65.00	06500	RESPIRATORY THERAPY	66,941	0	36,117	5,950	98,022	65.00
66.00	06600	PHYSICAL THERAPY	86,379	0	14,031	13,037	114,113	66.00
69.00	06900	ELECTROCARDIOLOGY	9,834	0	491	0	48,132	69.00
69.01	06901	CATH LAB	30,998	0	2,557	32,709	140,621	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	8,971	0	3,106	0	17,234	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	401,366	0	53,618	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	2,410,909	287,753	73.00
76.00	03020	DIABETIC EDUCATION	0	0	0	681	641	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	97,210	16,679	27,188	90.00
91.00	09100	EMERGENCY	245,336	276,984	107,095	11,836	254,093	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	14,723	156,471	40,904	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,155,171	1,165,152	1,223,710	2,998,193	2,943,148	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,955	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	1,668	0	0	0	0	192.03
192.04	19204	SMART STEPS	0	0	0	0	0	192.04
192.05	19205	RESPITE CARE	1,323	0	0	0	0	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,160,117	1,165,152	1,223,710	2,998,193	2,943,148	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part I | Date/Time Prepared: 5/22/2014 2:03 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
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
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	20,637,678	0	20,637,678		30.00
31.00	03100	INTENSIVE CARE UNIT	3,196,531	0	3,196,531		31.00
43.00	04300	NURSERY	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	11,586,825	0	11,586,825		50.00
50.01	05001	GI LAB	3,450,628	0	3,450,628		50.01
50.02	05002	AMBULATORY CARE UNIT	2,482,630	0	2,482,630		50.02
51.00	05100	RECOVERY ROOM	1,065,433	0	1,065,433		51.00
53.00	05300	ANESTHESIOLOGY	588,979	0	588,979		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,020,492	0	9,020,492		54.00
60.00	06000	LABORATORY	6,634,939	0	6,634,939		60.00
65.00	06500	RESPIRATORY THERAPY	2,096,673	0	2,096,673		65.00
66.00	06600	PHYSICAL THERAPY	4,733,458	0	4,733,458		66.00
69.00	06900	ELECTROCARDIOLOGY	408,510	0	408,510		69.00
69.01	06901	CATH LAB	2,837,629	0	2,837,629		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	287,318	0	287,318		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	992,503	0	992,503		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,481,961	0	6,481,961		73.00
76.00	03020	DIABETIC EDUCATION	178,137	0	178,137		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1,213,080	0	1,213,080		90.00
91.00	09100	EMERGENCY	7,805,207	0	7,805,207		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	2,681,638	0	2,681,638		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	88,380,249	0	88,380,249		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	156,429	0	156,429		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,485	0	8,485		192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0		192.01
192.02	19202	SENIOR PROGRAM	0	0	0		192.02
192.03	19203	NA VOLUNTEER SERVICES	48,138	0	48,138		192.03
192.04	19204	SMART STEPS	0	0	0		192.04
192.05	19205	RESPITE CARE	22,174	0	22,174		192.05
193.00	19300	NONPAID WORKERS	0	0	0		193.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	88,615,475	0	88,615,475		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part II Date/Time Prepared: 5/22/2014 2:03 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	11,516	200	11,716	11,716	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	390,089	29,273	419,362	853	5.00
7.00	00700	OPERATION OF PLANT	0	206,874	21,956	228,830	95	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	13,861	0	13,861	0	8.00
9.00	00900	HOUSEKEEPING	0	30,410	6,366	36,776	0	9.00
10.00	01000	DIETARY	0	68,451	19,440	87,891	0	10.00
11.00	01100	CAFETERIA	0	58,420	0	58,420	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,210	30,193	32,403	236	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,285	0	5,285	33	14.00
15.00	01500	PHARMACY	0	14,370	28,032	42,402	451	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	25,898	8,726	34,624	407	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	337,170	234,488	571,658	3,271	30.00
31.00	03100	INTENSIVE CARE UNIT	0	25,548	109,340	134,888	547	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	128,068	249,515	377,583	622	50.00
50.01	05001	GI LAB	0	41,312	64,667	105,979	377	50.01
50.02	05002	AMBULATORY CARE UNIT	0	55,511	25,037	80,548	391	50.02
51.00	05100	RECOVERY ROOM	0	9,877	520	10,397	205	51.00
53.00	05300	ANESTHESIOLOGY	0	5,095	155,679	160,774	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	103,587	425,324	528,911	772	54.00
60.00	06000	LABORATORY	0	52,466	85,395	137,861	536	60.00
65.00	06500	RESPIRATORY THERAPY	0	43,105	44,887	87,992	285	65.00
66.00	06600	PHYSICAL THERAPY	0	67,180	71,489	138,669	826	66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,880	16,585	20,465	64	69.00
69.01	06901	CATH LAB	0	3,683	14,454	18,137	171	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,188	13,729	20,917	38	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	03020	DIABETIC EDUCATION	0	2,492	0	2,492	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	81,114	239,683	320,797	1,179	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	3,832	3,832	339	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,794,660	1,898,810	3,693,470	11,698	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,696	0	4,696	4	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,136	0	1,136	0	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	0	0	0	0	9	192.03
192.04	19204	SMART STEPS	0	0	0	0	0	192.04
192.05	19205	RESPITE CARE	0	0	0	0	5	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,800,492	1,898,810	3,699,302	11,716	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part II | Date/Time Prepared: 5/22/2014 2:03 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	420,215					5.00
7.00	00700	OPERATION OF PLANT	21,933	250,858				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,980	2,917	19,758			8.00
9.00	00900	HOUSEKEEPING	11,888	6,400	0	55,064		9.00
10.00	01000	DIETARY	5,752	14,405	0	3,284	111,332	10.00
11.00	01100	CAFETERIA	8,534	12,294	0	2,803	0	11.00
13.00	01300	NURSING ADMINISTRATION	5,269	465	0	106	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,573	1,112	0	254	0	14.00
15.00	01500	PHARMACY	13,384	3,024	0	689	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,690	5,450	0	1,242	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	70,918	70,960	7,890	16,176	104,878	30.00
31.00	03100	INTENSIVE CARE UNIT	12,645	5,377	1,040	1,226	6,454	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	46,599	26,952	1,416	6,144	0	50.00
50.01	05001	GI LAB	13,132	8,694	1,611	1,982	0	50.01
50.02	05002	AMBULATORY CARE UNIT	9,563	11,682	791	2,663	0	50.02
51.00	05100	RECOVERY ROOM	4,445	2,079	450	474	0	51.00
53.00	05300	ANESTHESIOLOGY	1,969	1,072	0	244	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,208	21,800	1,897	4,970	0	54.00
60.00	06000	LABORATORY	27,109	11,041	0	2,517	0	60.00
65.00	06500	RESPIRATORY THERAPY	7,700	9,071	0	2,068	0	65.00
66.00	06600	PHYSICAL THERAPY	19,322	14,138	485	3,223	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,546	816	0	186	0	69.00
69.01	06901	CATH LAB	12,305	775	374	177	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,011	1,513	12	345	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,549	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	17,939	0	0	0	0	73.00
76.00	03020	DIABETIC EDUCATION	766	524	0	120	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,083	0	0	0	0	90.00
91.00	09100	EMERGENCY	29,772	17,070	3,792	3,892	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	11,710	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	419,294	249,631	19,758	54,785	111,332	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	595	988	0	225	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7	239	0	54	0	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	220	0	0	0	0	192.03
192.04	19204	SMART STEPS	0	0	0	0	0	192.04
192.05	19205	RESPITE CARE	99	0	0	0	0	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	420,215	250,858	19,758	55,064	111,332	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part II | Date/Time Prepared: 5/22/2014 2:03 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			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
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	82,051					11.00
13.00	01300	NURSING ADMINISTRATION	1,529	40,008				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	601	0	12,858			14.00
15.00	01500	PHARMACY	3,200	0	28	63,178		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,070	0	0	0	58,483	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,557	26,954	1,297	74	3,634	30.00
31.00	03100	INTENSIVE CARE UNIT	3,434	3,543	194	15	571	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,485	0	550	5,671	9,016	50.00
50.01	05001	GI LAB	3,043	0	1,248	66	3,344	50.01
50.02	05002	AMBULATORY CARE UNIT	2,820	0	83	65	216	50.02
51.00	05100	RECOVERY ROOM	1,132	0	31	0	372	51.00
53.00	05300	ANESTHESIOLOGY	0	0	401	947	1,171	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,486	0	912	469	11,739	54.00
60.00	06000	LABORATORY	5,472	0	1,003	66	6,967	60.00
65.00	06500	RESPIRATORY THERAPY	2,543	0	379	125	1,943	65.00
66.00	06600	PHYSICAL THERAPY	3,281	0	147	275	2,262	66.00
69.00	06900	ELECTROCARDIOLOGY	374	0	5	0	954	69.00
69.01	06901	CATH LAB	1,177	0	27	689	2,787	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	341	0	33	0	342	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	4,219	0	1,063	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	50,805	5,703	73.00
76.00	03020	DIABETIC EDUCATION	0	0	0	14	13	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	1,021	351	539	90.00
91.00	09100	EMERGENCY	9,319	9,511	1,125	249	5,036	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	155	3,297	811	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	81,864	40,008	12,858	63,178	58,483	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	74	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	63	0	0	0	0	192.03
192.04	19204	SMART STEPS	0	0	0	0	0	192.04
192.05	19205	RESPITE CARE	50	0	0	0	0	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	82,051	40,008	12,858	63,178	58,483	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part II | Date/Time Prepared: 5/22/2014 2:03 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
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
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	904,267	0	904,267		30.00
31.00	03100	INTENSIVE CARE UNIT	169,934	0	169,934		31.00
43.00	04300	NURSERY	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	480,038	0	480,038		50.00
50.01	05001	GI LAB	139,476	0	139,476		50.01
50.02	05002	AMBULATORY CARE UNIT	108,822	0	108,822		50.02
51.00	05100	RECOVERY ROOM	19,585	0	19,585		51.00
53.00	05300	ANESTHESIOLOGY	166,578	0	166,578		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	614,164	0	614,164		54.00
60.00	06000	LABORATORY	192,572	0	192,572		60.00
65.00	06500	RESPIRATORY THERAPY	112,106	0	112,106		65.00
66.00	06600	PHYSICAL THERAPY	182,628	0	182,628		66.00
69.00	06900	ELECTROCARDIOLOGY	24,410	0	24,410		69.00
69.01	06901	CATH LAB	36,619	0	36,619		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	24,552	0	24,552		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,831	0	7,831		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	74,447	0	74,447		73.00
76.00	03020	DIABETIC EDUCATION	3,929	0	3,929		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	6,994	0	6,994		90.00
91.00	09100	EMERGENCY	401,742	0	401,742		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	20,144	0	20,144		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,690,838	0	3,690,838		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,582	0	6,582		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,436	0	1,436		192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0		192.01
192.02	19202	SENIOR PROGRAM	0	0	0		192.02
192.03	19203	NA VOLUNTEER SERVICES	292	0	292		192.03
192.04	19204	SMART STEPS	0	0	0		192.04
192.05	19205	RESPITE CARE	154	0	154		192.05
193.00	19300	NONPAID WORKERS	0	0	0		193.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	3,699,302	0	3,699,302		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B-1 | Date/Time Prepared: 5/22/2014 2:03 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	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	293,311					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,899,861				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,876	200	29,935,763			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	63,548	29,289	2,181,706	-20,645,094	67,970,381	5.00
7.00	00700	OPERATION OF PLANT	33,701	21,968	242,387	0	3,547,828	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,258	0	0	0	482,006	8.00
9.00	00900	HOUSEKEEPING	4,954	6,370	0	0	1,922,996	9.00
10.00	01000	DIETARY	11,151	19,451	0	0	930,367	10.00
11.00	01100	CAFETERIA	9,517	0	0	0	1,380,500	11.00
13.00	01300	NURSING ADMINISTRATION	360	30,210	603,529	0	852,370	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	861	0	83,539	0	901,484	14.00
15.00	01500	PHARMACY	2,341	28,048	1,154,435	0	2,165,059	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,219	8,731	1,041,023	0	2,052,775	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	54,927	234,618	8,335,204	0	11,467,804	30.00
31.00	03100	INTENSIVE CARE UNIT	4,162	109,400	1,400,003	0	2,045,407	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,863	249,653	1,589,579	0	7,537,814	50.00
50.01	05001	GI LAB	6,730	64,703	965,148	0	2,124,218	50.01
50.02	05002	AMBULATORY CARE UNIT	9,043	25,051	1,000,173	0	1,546,914	50.02
51.00	05100	RECOVERY ROOM	1,609	520	525,131	0	719,074	51.00
53.00	05300	ANESTHESIOLOGY	830	155,765	0	0	318,572	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,875	425,558	1,973,566	0	5,695,313	54.00
60.00	06000	LABORATORY	8,547	85,442	1,370,842	0	4,385,221	60.00
65.00	06500	RESPIRATORY THERAPY	7,022	44,912	730,011	0	1,245,492	65.00
66.00	06600	PHYSICAL THERAPY	10,944	71,529	2,113,702	0	3,125,498	66.00
69.00	06900	ELECTROCARDIOLOGY	632	16,594	164,221	0	250,147	69.00
69.01	06901	CATH LAB	600	14,462	437,826	0	1,990,532	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,171	13,737	97,407	0	163,579	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	412,291	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	2,901,888	73.00
76.00	03020	DIABETIC EDUCATION	406	0	164	0	123,832	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	822,254	90.00
91.00	09100	EMERGENCY	13,214	239,816	3,014,808	0	4,815,901	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	3,834	866,751	0	1,894,201	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	292,361	1,899,861	29,891,155	-20,645,094	67,821,337	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	765	0	10,723	0	96,271	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	185	0	0	0	1,136	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	0	0	22,248	0	35,644	192.03
192.04	19204	SMART STEPS	0	0	0	0	0	192.04
192.05	19205	RESPITE CARE	0	0	11,637	0	15,993	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,800,492	1,898,810	9,505,218		20,645,094	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.138508	0.999447	0.317520		0.303737	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			11,716		420,215	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000391		0.006182	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B-1 | Date/Time Prepared: 5/22/2014 2:03 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		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
7.00	00700	OPERATION OF PLANT	194,186					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,258	570,956				8.00
9.00	00900	HOUSEKEEPING	4,954	0	186,974			9.00
10.00	01000	DIETARY	11,151	0	11,151	61,702		10.00
11.00	01100	CAFETERIA	9,517	0	9,517	0	37,561	11.00
13.00	01300	NURSING ADMINISTRATION	360	0	360	0	700	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	861	0	861	0	275	14.00
15.00	01500	PHARMACY	2,341	0	2,341	0	1,465	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,219	0	4,219	0	1,863	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	54,927	228,002	54,927	58,125	12,157	30.00
31.00	03100	INTENSIVE CARE UNIT	4,162	30,052	4,162	3,577	1,572	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,863	40,924	20,863	0	2,511	50.00
50.01	05001	GI LAB	6,730	46,548	6,730	0	1,393	50.01
50.02	05002	AMBULATORY CARE UNIT	9,043	22,872	9,043	0	1,291	50.02
51.00	05100	RECOVERY ROOM	1,609	13,009	1,609	0	518	51.00
53.00	05300	ANESTHESIOLOGY	830	0	830	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,875	54,828	16,875	0	3,427	54.00
60.00	06000	LABORATORY	8,547	3	8,547	0	2,505	60.00
65.00	06500	RESPIRATORY THERAPY	7,022	0	7,022	0	1,164	65.00
66.00	06600	PHYSICAL THERAPY	10,944	14,008	10,944	0	1,502	66.00
69.00	06900	ELECTROCARDIOLOGY	632	0	632	0	171	69.00
69.01	06901	CATH LAB	600	10,795	600	0	539	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,171	342	1,171	0	156	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	03020	DIABETIC EDUCATION	406	0	406	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	13,214	109,573	13,214	0	4,266	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	193,236	570,956	186,024	61,702	37,475	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	765	0	765	0	34	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	185	0	185	0	0	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	0	0	0	0	29	192.03
192.04	19204	SMART STEPS	0	0	0	0	0	192.04
192.05	19205	RESPITE CARE	0	0	0	0	23	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,625,435	682,194	2,625,083	1,635,124	2,160,117	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.819611	1.194828	14.039829	26.500340	57.509571	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	250,858	19,758	55,064	111,332	82,051	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.291844	0.034605	0.294501	1.804350	2.184473	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B-1 | Date/Time Prepared: 5/22/2014 2:03 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			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
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	418,482					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,351,455				14.00
15.00	01500	PHARMACY	0	5,081	3,538,993			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	351,373,653		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	281,940	237,215	4,125	21,892,104		30.00
31.00	03100	INTENSIVE CARE UNIT	37,059	35,510	864	3,437,172		31.00
43.00	04300	NURSERY	0	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	100,505	317,663	54,311,066		50.00
50.01	05001	GI LAB	0	228,315	3,723	20,142,499		50.01
50.02	05002	AMBULATORY CARE UNIT	0	15,260	3,657	1,299,706		50.02
51.00	05100	RECOVERY ROOM	0	5,659	0	2,239,152		51.00
53.00	05300	ANESTHESIOLOGY	0	73,425	53,033	7,053,781		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	166,708	26,298	69,812,517		54.00
60.00	06000	LABORATORY	0	183,453	3,676	41,968,856		60.00
65.00	06500	RESPIRATORY THERAPY	0	69,402	7,023	11,702,668		65.00
66.00	06600	PHYSICAL THERAPY	0	26,962	15,388	13,623,812		66.00
69.00	06900	ELECTROCARDIOLOGY	0	943	0	5,746,478		69.00
69.01	06901	CATH LAB	0	4,913	38,609	16,788,546		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,968	0	2,057,501		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	771,256	0	6,401,362		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,845,777	34,354,463		73.00
76.00	03020	DIABETIC EDUCATION	0	0	804	76,583		76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	186,797	19,687	3,245,989		90.00
91.00	09100	EMERGENCY	99,483	205,791	13,971	30,335,889		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	28,292	184,695	4,883,509		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	418,482	2,351,455	3,538,993	351,373,653		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	0		192.01
192.02	19202	SENIOR PROGRAM	0	0	0	0		192.02
192.03	19203	NA VOLUNTEER SERVICES	0	0	0	0		192.03
192.04	19204	SMART STEPS	0	0	0	0		192.04
192.05	19205	RESPITE CARE	0	0	0	0		192.05
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,165,152	1,223,710	2,998,193	2,943,148		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.784234	0.520405	0.847188	0.008376		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	40,008	12,858	63,178	58,483		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.095603	0.005468	0.017852	0.000166		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/22/2014 2:03 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,637,678		20,637,678	0	20,637,678	30.00
31.00	03100	INTENSIVE CARE UNIT	3,196,531		3,196,531	0	3,196,531	31.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,586,825		11,586,825	0	11,586,825	50.00
50.01	05001	GI LAB	3,450,628		3,450,628	0	3,450,628	50.01
50.02	05002	AMBULATORY CARE UNIT	2,482,630		2,482,630	0	2,482,630	50.02
51.00	05100	RECOVERY ROOM	1,065,433		1,065,433	0	1,065,433	51.00
53.00	05300	ANESTHESIOLOGY	588,979		588,979	0	588,979	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,020,492		9,020,492	0	9,020,492	54.00
60.00	06000	LABORATORY	6,634,939		6,634,939	0	6,634,939	60.00
65.00	06500	RESPIRATORY THERAPY	2,096,673	0	2,096,673	0	2,096,673	65.00
66.00	06600	PHYSICAL THERAPY	4,733,458	0	4,733,458	0	4,733,458	66.00
69.00	06900	ELECTROCARDIOLOGY	408,510		408,510	0	408,510	69.00
69.01	06901	CATH LAB	2,837,629		2,837,629	0	2,837,629	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	287,318		287,318	0	287,318	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	992,503		992,503	0	992,503	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,481,961		6,481,961	0	6,481,961	73.00
76.00	03020	DIABETIC EDUCATION	178,137		178,137	0	178,137	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,213,080		1,213,080	0	1,213,080	90.00
91.00	09100	EMERGENCY	7,805,207		7,805,207	0	7,805,207	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,944,300		3,944,300		3,944,300	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,681,638		2,681,638		2,681,638	116.00
200.00		Subtotal (see instructions)	92,324,549	0	92,324,549	0	92,324,549	200.00
201.00		Less Observation Beds	3,944,300		3,944,300		3,944,300	201.00
202.00		Total (see instructions)	88,380,249	0	88,380,249	0	88,380,249	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/22/2014 2:03 pm

Title XVIII | 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	17,572,736		17,572,736			30.00
31.00	03100	INTENSIVE CARE UNIT	3,437,172		3,437,172			31.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,219,503	30,091,563	54,311,066	0.213342	0.000000	50.00
50.01	05001	GI LAB	3,702,058	16,440,441	20,142,499	0.171311	0.000000	50.01
50.02	05002	AMBULATORY CARE UNIT	310,630	989,076	1,299,706	1.910147	0.000000	50.02
51.00	05100	RECOVERY ROOM	839,159	1,399,993	2,239,152	0.475820	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	2,511,507	4,542,274	7,053,781	0.083498	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,228,209	58,584,308	69,812,517	0.129210	0.000000	54.00
60.00	06000	LABORATORY	9,745,750	32,223,106	41,968,856	0.158092	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,356,299	3,346,369	11,702,668	0.179162	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,080,012	10,543,800	13,623,812	0.347440	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	1,844,059	3,902,419	5,746,478	0.071089	0.000000	69.00
69.01	06901	CATH LAB	5,260,544	11,528,002	16,788,546	0.169022	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	36,729	2,020,772	2,057,501	0.139644	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,297,501	2,103,861	6,401,362	0.155046	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,846,045	14,508,418	34,354,463	0.188679	0.000000	73.00
76.00	03020	DIABETIC EDUCATION	0	76,583	76,583	2.326065	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,146	3,241,843	3,245,989	0.373717	0.000000	90.00
91.00	09100	EMERGENCY	6,054,481	24,281,408	30,335,889	0.257293	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	644,710	3,674,658	4,319,368	0.913166	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	4,883,509	4,883,509			116.00
200.00		Subtotal (see instructions)	122,991,250	228,382,403	351,373,653			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	122,991,250	228,382,403	351,373,653			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/22/2014 2:03 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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.213342		50.00
50.01	05001	GI LAB	0.171311		50.01
50.02	05002	AMBULATORY CARE UNIT	1.910147		50.02
51.00	05100	RECOVERY ROOM	0.475820		51.00
53.00	05300	ANESTHESIOLOGY	0.083498		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129210		54.00
60.00	06000	LABORATORY	0.158092		60.00
65.00	06500	RESPIRATORY THERAPY	0.179162		65.00
66.00	06600	PHYSICAL THERAPY	0.347440		66.00
69.00	06900	ELECTROCARDIOLOGY	0.071089		69.00
69.01	06901	CATH LAB	0.169022		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.139644		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.155046		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.188679		73.00
76.00	03020	DIABETIC EDUCATION	2.326065		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.373717		90.00
91.00	09100	EMERGENCY	0.257293		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.913166		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
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: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/22/2014 2:03 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,637,678		20,637,678	0	20,637,678	30.00
31.00	03100	INTENSIVE CARE UNIT	3,196,531		3,196,531	0	3,196,531	31.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,586,825		11,586,825	0	11,586,825	50.00
50.01	05001	GI LAB	3,450,628		3,450,628	0	3,450,628	50.01
50.02	05002	AMBULATORY CARE UNIT	2,482,630		2,482,630	0	2,482,630	50.02
51.00	05100	RECOVERY ROOM	1,065,433		1,065,433	0	1,065,433	51.00
53.00	05300	ANESTHESIOLOGY	588,979		588,979	0	588,979	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,020,492		9,020,492	0	9,020,492	54.00
60.00	06000	LABORATORY	6,634,939		6,634,939	0	6,634,939	60.00
65.00	06500	RESPIRATORY THERAPY	2,096,673	0	2,096,673	0	2,096,673	65.00
66.00	06600	PHYSICAL THERAPY	4,733,458	0	4,733,458	0	4,733,458	66.00
69.00	06900	ELECTROCARDIOLOGY	408,510		408,510	0	408,510	69.00
69.01	06901	CATH LAB	2,837,629		2,837,629	0	2,837,629	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	287,318		287,318	0	287,318	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	992,503		992,503	0	992,503	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,481,961		6,481,961	0	6,481,961	73.00
76.00	03020	DIABETIC EDUCATION	178,137		178,137	0	178,137	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,213,080		1,213,080	0	1,213,080	90.00
91.00	09100	EMERGENCY	7,805,207		7,805,207	0	7,805,207	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,944,300		3,944,300		3,944,300	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,681,638		2,681,638		2,681,638	116.00
200.00		Subtotal (see instructions)	92,324,549	0	92,324,549	0	92,324,549	200.00
201.00		Less Observation Beds	3,944,300		3,944,300		3,944,300	201.00
202.00		Total (see instructions)	88,380,249	0	88,380,249	0	88,380,249	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/22/2014 2:03 pm

Title XIX | Hospital | Cost

		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	17,572,736		17,572,736			30.00
31.00	03100	INTENSIVE CARE UNIT	3,437,172		3,437,172			31.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,219,503	30,091,563	54,311,066	0.213342	0.000000	50.00
50.01	05001	GI LAB	3,702,058	16,440,441	20,142,499	0.171311	0.000000	50.01
50.02	05002	AMBULATORY CARE UNIT	310,630	989,076	1,299,706	1.910147	0.000000	50.02
51.00	05100	RECOVERY ROOM	839,159	1,399,993	2,239,152	0.475820	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	2,511,507	4,542,274	7,053,781	0.083498	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,228,209	58,584,308	69,812,517	0.129210	0.000000	54.00
60.00	06000	LABORATORY	9,745,750	32,223,106	41,968,856	0.158092	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,356,299	3,346,369	11,702,668	0.179162	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,080,012	10,543,800	13,623,812	0.347440	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	1,844,059	3,902,419	5,746,478	0.071089	0.000000	69.00
69.01	06901	CATH LAB	5,260,544	11,528,002	16,788,546	0.169022	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	36,729	2,020,772	2,057,501	0.139644	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,297,501	2,103,861	6,401,362	0.155046	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,846,045	14,508,418	34,354,463	0.188679	0.000000	73.00
76.00	03020	DIABETIC EDUCATION	0	76,583	76,583	2.326065	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,146	3,241,843	3,245,989	0.373717	0.000000	90.00
91.00	09100	EMERGENCY	6,054,481	24,281,408	30,335,889	0.257293	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	644,710	3,674,658	4,319,368	0.913166	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	4,883,509	4,883,509			116.00
200.00		Subtotal (see instructions)	122,991,250	228,382,403	351,373,653			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	122,991,250	228,382,403	351,373,653			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/22/2014 2:03 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
50.01	05001	GI LAB	0.000000		50.01
50.02	05002	AMBULATORY CARE UNIT	0.000000		50.02
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CATH LAB	0.000000		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	DIABETIC EDUCATION	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part I Date/Time Prepared: 5/22/2014 2:03 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	904,267	0	904,267	17,209	52.55	30.00
31.00	INTENSIVE CARE UNIT	169,934		169,934	1,547	109.85	31.00
43.00	NURSERY	0		0	767	0.00	43.00
200.00	Total (lines 30-199)	1,074,201		1,074,201	19,523		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	7,396	388,660				30.00
31.00	INTENSIVE CARE UNIT	865	95,020				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30-199)	8,261	483,680				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part II Date/Time Prepared: 5/22/2014 2:03 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	480,038	54,311,066	0.008839	11,457,496	101,273	50.00
50.01	05001	GI LAB	139,476	20,142,499	0.006924	3,646,020	25,245	50.01
50.02	05002	AMBULATORY CARE UNIT	108,822	1,299,706	0.083728	239,013	20,012	50.02
51.00	05100	RECOVERY ROOM	19,585	2,239,152	0.008747	323,098	2,826	51.00
53.00	05300	ANESTHESIOLOGY	166,578	7,053,781	0.023615	939,894	22,196	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	614,164	69,812,517	0.008797	6,594,772	58,014	54.00
60.00	06000	LABORATORY	192,572	41,968,856	0.004588	5,927,233	27,194	60.00
65.00	06500	RESPIRATORY THERAPY	112,106	11,702,668	0.009580	5,502,319	52,712	65.00
66.00	06600	PHYSICAL THERAPY	182,628	13,623,812	0.013405	1,977,646	26,510	66.00
69.00	06900	ELECTROCARDIOLOGY	24,410	5,746,478	0.004248	1,259,153	5,349	69.00
69.01	06901	CATH LAB	36,619	16,788,546	0.002181	3,222,949	7,029	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	24,552	2,057,501	0.011933	21,937	262	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,831	6,401,362	0.001223	4,420	5	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	74,447	34,354,463	0.002167	11,001,375	23,840	73.00
76.00	03020	DIABETIC EDUCATION	3,929	76,583	0.051304	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,994	3,245,989	0.002155	2,184	5	90.00
91.00	09100	EMERGENCY	401,742	30,335,889	0.013243	3,283,057	43,478	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	172,823	4,319,368	0.040011	423,918	16,961	92.00
200.00		Total (lines 50-199)	2,769,316	325,480,236		55,826,484	432,911	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part III Date/Time Prepared: 5/22/2014 2:03 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
43.00	04300	NURSERY	0	0	0		0	43.00
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	17,209	0.00	7,396	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,547	0.00	865	0		31.00
43.00	04300	NURSERY	767	0.00	0	0		43.00
200.00		Total (lines 30-199)	19,523		8,261	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV Date/Time Prepared: 5/22/2014 2:03 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
50.01	05001	GI LAB	0	0	0	0	0	50.01
50.02	05002	AMBULATORY CARE UNIT	0	0	0	0	0	50.02
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CATH LAB	0	0	0	0	0	69.01
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	03020	DIABETIC EDUCATION	0	0	0	0	0	76.00
		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: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV Date/Time Prepared: 5/22/2014 2:03 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	54,311,066	0.000000	0.000000	11,457,496	50.00
50.01	05001	GI LAB	0	20,142,499	0.000000	0.000000	3,646,020	50.01
50.02	05002	AMBULATORY CARE UNIT	0	1,299,706	0.000000	0.000000	239,013	50.02
51.00	05100	RECOVERY ROOM	0	2,239,152	0.000000	0.000000	323,098	51.00
53.00	05300	ANESTHESIOLOGY	0	7,053,781	0.000000	0.000000	939,894	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	69,812,517	0.000000	0.000000	6,594,772	54.00
60.00	06000	LABORATORY	0	41,968,856	0.000000	0.000000	5,927,233	60.00
65.00	06500	RESPIRATORY THERAPY	0	11,702,668	0.000000	0.000000	5,502,319	65.00
66.00	06600	PHYSICAL THERAPY	0	13,623,812	0.000000	0.000000	1,977,646	66.00
69.00	06900	ELECTROCARDIOLOGY	0	5,746,478	0.000000	0.000000	1,259,153	69.00
69.01	06901	CATH LAB	0	16,788,546	0.000000	0.000000	3,222,949	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,057,501	0.000000	0.000000	21,937	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,401,362	0.000000	0.000000	4,420	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	34,354,463	0.000000	0.000000	11,001,375	73.00
76.00	03020	DIABETIC EDUCATION	0	76,583	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	3,245,989	0.000000	0.000000	2,184	90.00
91.00	09100	EMERGENCY	0	30,335,889	0.000000	0.000000	3,283,057	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	4,319,368	0.000000	0.000000	423,918	92.00
200.00		Total (lines 50-199)	0	325,480,236			55,826,484	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV Date/Time Prepared: 5/22/2014 2:03 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	8,134,017	0		50.00
50.01	05001	GI LAB	0	6,358,368	0		50.01
50.02	05002	AMBULATORY CARE UNIT	0	586,777	0		50.02
51.00	05100	RECOVERY ROOM	0	299,122	0		51.00
53.00	05300	ANESTHESIOLOGY	0	1,273,682	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,021,437	0		54.00
60.00	06000	LABORATORY	0	774,610	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,236,581	0		65.00
66.00	06600	PHYSICAL THERAPY	0	789,295	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,502,424	0		69.00
69.01	06901	CATH LAB	0	4,372,791	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	582,228	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	735,224	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,997,026	0		73.00
76.00	03020	DIABETIC EDUCATION	0	542	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	2,133,284	0		90.00
91.00	09100	EMERGENCY	0	4,924,273	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,454,337	0		92.00
200.00		Total (lines 50-199)	0	55,176,018	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part V Date/Time Prepared: 5/22/2014 2:03 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	0.213342	8,134,017	0	8,755	1,735,327	50.00
50.01	05001	GI LAB	0.171311	6,358,368	0	0	1,089,258	50.01
50.02	05002	AMBULATORY CARE UNIT	1.910147	586,777	0	0	1,120,830	50.02
51.00	05100	RECOVERY ROOM	0.475820	299,122	0	0	142,328	51.00
53.00	05300	ANESTHESIOLOGY	0.083498	1,273,682	0	0	106,350	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129210	16,021,437	0	26,544	2,070,130	54.00
60.00	06000	LABORATORY	0.158092	774,610	1,411	0	122,460	60.00
65.00	06500	RESPIRATORY THERAPY	0.179162	1,236,581	11	0	221,548	65.00
66.00	06600	PHYSICAL THERAPY	0.347440	789,295	0	0	274,233	66.00
69.00	06900	ELECTROCARDIOLOGY	0.071089	1,502,424	0	0	106,806	69.00
69.01	06901	CATH LAB	0.169022	4,372,791	0	1,207	739,098	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.139644	582,228	0	0	81,305	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.155046	735,224	0	0	113,994	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.188679	3,997,026	0	53,834	754,155	73.00
76.00	03020	DIABETIC EDUCATION	2.326065	542	0	0	1,261	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.373717	2,133,284	0	7,322	797,244	90.00
91.00	09100	EMERGENCY	0.257293	4,924,273	0	0	1,266,981	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.913166	1,454,337	0	0	1,328,051	92.00
200.00		Subtotal (see instructions)		55,176,018	1,422	97,662	12,071,359	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		55,176,018	1,422	97,662	12,071,359	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part V Date/Time Prepared: 5/22/2014 2:03 pm

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		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	1,868		50.00
50.01	05001	GI LAB	0	0		50.01
50.02	05002	AMBULATORY CARE UNIT	0	0		50.02
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,430		54.00
60.00	06000	LABORATORY	223	0		60.00
65.00	06500	RESPIRATORY THERAPY	2	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CATH LAB	0	204		69.01
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	10,157		73.00
76.00	03020	DIABETIC EDUCATION	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	2,736		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)	225	18,395		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	225	18,395		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140160	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/22/2014 2:03 pm
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	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)	17,209	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	17,209	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)	13,920	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)	7,396	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)	20,637,678	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)	20,637,678	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)	20,637,678	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,199.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	8,869,579	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)	8,869,579	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/22/2014 2:03 pm

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	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	3,196,531	1,547	2,066.28	865	1,787,332	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)	11,166,179	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	21,823,090	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)	483,680	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	432,911	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	916,591	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	20,906,499	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	3,289	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,199.24	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,944,300	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/22/2014 2:03 pm

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	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	904,267	20,637,678	0.043816	3,944,300	172,823	90.00
91.00	Nursing School cost	0	20,637,678	0.000000	3,944,300	0	91.00
92.00	Allied health cost	0	20,637,678	0.000000	3,944,300	0	92.00
93.00	All other Medical Education	0	20,637,678	0.000000	3,944,300	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-3 | Date/Time Prepared: 5/22/2014 2:03 pm

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		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		8,350,065		30.00
31.00	03100	INTENSIVE CARE UNIT		1,793,232		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.213342	11,457,496	2,444,365	50.00
50.01	05001	GI LAB	0.171311	3,646,020	624,603	50.01
50.02	05002	AMBULATORY CARE UNIT	1.910147	239,013	456,550	50.02
51.00	05100	RECOVERY ROOM	0.475820	323,098	153,736	51.00
53.00	05300	ANESTHESIOLOGY	0.083498	939,894	78,479	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129210	6,594,772	852,110	54.00
60.00	06000	LABORATORY	0.158092	5,927,233	937,048	60.00
65.00	06500	RESPIRATORY THERAPY	0.179162	5,502,319	985,806	65.00
66.00	06600	PHYSICAL THERAPY	0.347440	1,977,646	687,113	66.00
69.00	06900	ELECTROCARDIOLOGY	0.071089	1,259,153	89,512	69.00
69.01	06901	CATH LAB	0.169022	3,222,949	544,749	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.139644	21,937	3,063	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.155046	4,420	685	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.188679	11,001,375	2,075,728	73.00
76.00	03020	DIABETIC EDUCATION	2.326065	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.373717	2,184	816	90.00
91.00	09100	EMERGENCY	0.257293	3,283,057	844,708	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.913166	423,918	387,108	92.00
200.00		Total (sum of lines 50-94 and 96-98)		55,826,484	11,166,179	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)		55,826,484		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140160	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/22/2014 2:03 pm
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		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)		10,629,364		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		3,584,585		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)		599,144		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)		90.99		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)		3.44		30.00
31.00	Percentage of Medicaid patient days (see instructions)		15.51		31.00
32.00	Sum of lines 30 and 31		18.95		32.00
33.00	Allowable disproportionate share percentage (see instructions)		5.07		33.00
34.00	Disproportionate share adjustment (see instructions)		584,344		34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E Part A Date/Time Prepared: 5/22/2014 2:03 pm

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			Prior to October 1	On/After October 1	
		0	1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)			9,046,380,143	35.00
35.01	Factor 3 (see instructions)			0.000103981	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			940,651	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			237,096	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		237,096		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)		15,634,533		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		15,798,554		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		15,757,549		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		1,146,576		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0		55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0		56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).		0		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		16,904,125		59.00
60.00	Primary payer payments		14,060		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		16,890,065		61.00
62.00	Deductibles billed to program beneficiaries		1,751,648		62.00
63.00	Coinsurance billed to program beneficiaries		35,224		63.00
64.00	Allowable bad debts (see instructions)		366,619		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		238,302		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		366,619		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		15,341,495		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)		30,599		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		-34,927		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: 140160	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/22/2014 2:03 pm
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			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)		15,337,167		71.00
71.01	Sequestration adjustment (see instructions)		231,591		71.01
72.00	Interim payments		15,432,493		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		-326,917		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: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/22/2014 2:03 pm

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		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	14,331,880	14,331,880	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013	1.01	10,629,364	0	10,629,364	0	10,629,364	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013	1.02	3,584,585	0	0	3,584,585	3,584,585	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	599,144	0	427,009	172,135	599,144	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	0.0507	0.0507	0.0507	0.0507		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	584,344	0	357,253	227,091	584,344	11.00
11.01	Uncompensated care payments	36.00	237,096	237,096	0	0	237,096	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	15,634,533	237,096	11,413,626	3,983,811	15,634,533	13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	48.00	15,798,554	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49.00	15,757,549	237,096	11,536,642	3,983,811	15,757,549	15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50.00	1,146,576	0	857,176	289,400	1,146,576	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			237,096	12,393,818	4,273,211	16,904,125	19.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/22/2014 2:03 pm

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		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	1,128,949	0	843,291	285,658	1,128,949	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	17,627	0	13,885	3,742	17,627	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (line 20 times line 22)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (line 20 times line 24)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	12.00	1,146,576	0	857,176	289,400	1,146,576	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: 140160	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/22/2014 2:03 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	18,620	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	12,071,359	2.00
3.00	PPS payments	10,056,145	3.00
4.00	Outlier payment (see instructions)	85,836	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.822	5.00
6.00	Line 2 times line 5	9,922,657	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)	18,620	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	99,084	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)	99,084	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)	99,084	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	80,464	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)	18,620	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)	10,141,981	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)	2,255,958	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)	7,904,643	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)	7,904,643	30.00
31.00	Primary payer payments	243	31.00
32.00	Subtotal (line 30 minus line 31)	7,904,400	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)	413,039	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	268,475	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	412,409	36.00
37.00	Subtotal (see instructions)	8,172,875	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-11	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)	8,172,886	40.00
40.01	Sequestration adjustment (see instructions)	123,411	40.01
41.00	Interim payments	8,001,920	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	47,555	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E-1 Part I | Date/Time Prepared: 5/22/2014 2:03 pm

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		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		15,475,957		8,019,772	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	07/10/2013	43,464	07/10/2013	17,852	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)		-43,464		-17,852	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)		15,432,493		8,001,920	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		47,555	6.01
6.02	SETTLEMENT TO PROGRAM		326,917		0	6.02
7.00	Total Medicare program liability (see instructions)		15,105,576		8,049,475	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: 140160	Period: From 01/01/2013 To 12/31/2013	Worksheet E-1 Part II Date/Time Prepared: 5/22/2014 2:03 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	4,303	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	8,261	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	2,266	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	15,467	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	351,373,653	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	6,924,956	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)	1,369,923	8.00
9.00	Sequestration adjustment amount (see instructions)	27,398	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1,342,525	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	1,334,580	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)	7,945	32.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet G | Date/Time Prepared: 5/22/2014 2:03 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	16,257,456	0	0	0	1.00
2.00	Temporary investments	8,790,173	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	25,486,896	0	0	0	4.00
5.00	Other receivable	583,882	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	6,211,233	0	0	0	9.00
10.00	Due from other funds	896,332	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	58,225,972	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	19,609,263	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)	19,609,263	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,740,182	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,740,182	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	79,575,417	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,156,579	0	0	0	37.00
38.00	Salaries, wages, and fees payable	8,781,868	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	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	0	0	0	0	43.00
44.00	Other current liabilities	8,002,877	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	19,941,324	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	7,112,491	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	7,112,491	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	27,053,815	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	52,521,602				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)	52,521,602	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	79,575,417	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet G-1 | Date/Time Prepared: 5/22/2014 2:03 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		41,203,186		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		11,318,416				2.00
3.00	Total (sum of line 1 and line 2)		52,521,602		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		52,521,602		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	ROUNDING	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)		52,521,602		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00	ROUNDING		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: 140160 | Period: From 01/01/2013 To 12/31/2013 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/22/2014 2:03 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	25,995,829		25,995,829	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	25,995,829		25,995,829	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	3,437,172		3,437,172	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)	3,437,172		3,437,172	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	29,433,001		29,433,001	17.00
18.00	Ancillary services	97,517,505	203,651,135	301,168,640	18.00
19.00	Outpatient services	8,096,305	38,692,311	46,788,616	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	1	4,883,509	4,883,510	26.00
27.00		0	0	0	27.00
27.02		0	0	0	27.02
27.03		0	0	0	27.03
27.04		0	0	0	27.04
27.05		0	0	0	27.05
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	135,046,812	247,226,955	382,273,767	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		101,166,684		29.00
30.00	ROUNDING	1			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)		1		36.00
37.00	MEDICAL MALP IBNR ADJUSTMENT	331,367			37.00
38.00	FMH PHARMACY NONPATIENT MEDICAID	50			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		331,417		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		100,835,268		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 140160	Period: From 01/01/2013 To 12/31/2013	Worksheet G-3 Date/Time Prepared: 5/22/2014 2:03 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	382,273,767	1.00
2.00	Less contractual allowances and discounts on patients' accounts	243,196,851	2.00
3.00	Net patient revenues (line 1 minus line 2)	139,076,916	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	100,835,268	4.00
5.00	Net income from service to patients (line 3 minus line 4)	38,241,648	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	164,739	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	MEDICAID ASSESSMENT	7,136,642	24.00
24.01	OTHER GOV REV	2,073,627	24.01
24.02	OTHER OP REV	694,107	24.02
24.03	NET ASSETS	84,954	24.03
24.04	OTHER NON-OP	369,054	24.04
24.05	NET PENSION COSTS CHANGE	6,667,632	24.05
24.06		0	24.06
25.00	Total other income (sum of lines 6-24)	17,190,755	25.00
26.00	Total (line 5 plus line 25)	55,432,403	26.00
27.00	TRANSFER TO OTHER AFFILIATES	23,067,650	27.00
27.01	CHARITY CARE	7,752,116	27.01
27.02	BAD DEBT	12,955,481	27.02
27.03	LOSS ON SALE OF ASSETS	7,323	27.03
27.04	MEDICAL MALP IBNR ADJUSTMENT	331,367	27.04
27.05	FMH PHARMACY NONPATIENT MEDICAID	50	27.05
28.00	Total other expenses (sum of line 27 and subscripts)	44,113,987	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	11,318,416	29.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140160 | Hospice CCN: 141560 | Period: From 01/01/2013 To 12/31/2013 | Worksheet K | Date/Time Prepared: 5/22/2014 2:03 pm

Hospice I

		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	341	0	130,844	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	10,000	0	575	0	10,000	9.00
10.00	Nursing Care	856,526	0	25,810	348,482	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	226	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	4,476	0	0	15.00
16.00	Spiritual Counseling	0	0	1,886	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	24,299	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	184,695	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	26,998	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	866,752	0	57,387	348,482	352,537	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140160 Hospice CCN: 141560 | Period: From 01/01/2013 To 12/31/2013 | Worksheet K | Date/Time Prepared: 5/22/2014 2:03 pm

Hospice I

		Total (cols. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	131,185	0	131,185	0	131,185	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	20,575	0	20,575	-10,000	10,575	9.00
10.00	Nursing Care	1,230,818	0	1,230,818	0	1,230,818	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	226	0	226	0	226	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	4,476	0	4,476	0	4,476	15.00
16.00	Spiritual Counseling	1,886	0	1,886	0	1,886	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	24,299	0	24,299	0	24,299	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	184,695	0	184,695	0	184,695	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	26,998	0	26,998	0	26,998	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	1,625,158	0	1,625,158	-10,000	1,615,158	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140160 Hospice CCN: 141560

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

Worksheet K-1

Date/Time Prepared: 5/22/2014 2:03 pm

Hospice I

		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	104,174	0	469,523	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	104,174	0	469,523	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES | Provider CCN: 140160 Hospice CCN: 141560 | Period: From 01/01/2013 To 12/31/2013 | Worksheet K-1 | Date/Time Prepared: 5/22/2014 2:03 pm

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		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	0	0		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	10,000	10,000		9.00
10.00	Nursing Care		114,072	168,757	856,526		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	226	0	0	226		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	0		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	226	114,072	178,757	866,752		39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES | Provider CCN: 140160 Hospice CCN: 141560 | Period: From 01/01/2013 To 12/31/2013 | Worksheet K-3 Date/Time Prepared: 5/22/2014 2:03 pm

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		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	348,482	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	0	348,482	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES | Provider CCN: 140160 Hospice CCN: 141560 | Period: From 01/01/2013 To 12/31/2013 | Worksheet K-3 | Date/Time Prepared: 5/22/2014 2:03 pm

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	0	0		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	0		9.00
10.00	Nursing Care		0	0	348,482		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	0		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	348,482		39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140160
Hospice CCN: 141560

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

Worksheet K-4 Part I
Date/Time Prepared: 5/22/2014 2:03 pm

Hospice I

		NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COST		PLANT OPERATION & MAINT.	TRANSPORTATION	
			BUILDINGS & FIXTURES	MOVABLE EQUIPMENT			
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	131,185	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	10,575	0	0	0	0	9.00
10.00	Nursing Care	1,230,818	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	226	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	4,476	0	0	0	0	15.00
16.00	Spiritual Counseling	1,886	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	24,299	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	184,695	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	26,998	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	1,615,158	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST | Provider CCN: 140160 Hospice CCN: 141560 | Period: From 01/01/2013 To 12/31/2013 | Worksheet K-4 Part I Date/Time Prepared: 5/22/2014 2:03 pm

Hospice I

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (cols. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)		
		5.00	5A	6.00	7.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance						3.00
4.00	Transportation - Staff						4.00
5.00	Volunteer Service Coordination	0					5.00
6.00	Administrative and General	0	131,185	131,185			6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0		7.00
8.00	Inpatient - Respite Care	0	0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services	0	10,575	935	11,510		9.00
10.00	Nursing Care	0	1,230,818	108,805	1,339,623		10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0		11.00
12.00	Physical Therapy	0	226	20	246		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services	0	4,476	396	4,872		15.00
16.00	Spiritual Counseling	0	1,886	167	2,053		16.00
17.00	Dietary Counseling	0	0	0	0		17.00
18.00	Counseling - Other	0	0	0	0		18.00
19.00	Home Health Aide and Homemaker	0	24,299	2,148	26,447		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		20.00
21.00	Other	0	0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	184,695	16,327	201,022		22.00
23.00	Analgesics	0	0	0	0		23.00
24.00	Sedatives / Hypnotics	0	0	0	0		24.00
25.00	Other - Specify	0	0	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0		26.00
27.00	Patient Transportation	0	0	0	0		27.00
28.00	Imaging Services	0	0	0	0		28.00
29.00	Labs and Diagnostics	0	0	0	0		29.00
30.00	Medical Supplies	0	26,998	2,387	29,385		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0		31.00
32.00	Radiation Therapy	0	0	0	0		32.00
33.00	Chemotherapy	0	0	0	0		33.00
34.00	Other	0	0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0		35.00
36.00	Volunteer Program Costs	0	0	0	0		36.00
37.00	Fundraising	0	0	0	0		37.00
38.00	Other Program Costs	0	0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	1,615,158		1,615,158		39.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140160 Hospice CCN: 141560 | Period: From 01/01/2013 To 12/31/2013 | Worksheet K-4 Part II Date/Time Prepared: 5/22/2014 2:03 pm

Hospice I

		CAPITAL RELATED COST					
		BUILDINGS & FIXTURES (SQ. FT.)	MOVABLE EQUIPMENT ($ VALUE)	PLANT OPERATION & MAINT. (SQ. FT.)	TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICES COORDINATOR (HOURS)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	100					1.00
2.00	Capital Related Costs-Movable Equip.	0	100				2.00
3.00	Plant Operation and Maintenance	0	0	100			3.00
4.00	Transportation - Staff	0	0	0	100		4.00
5.00	Volunteer Service Coordination	0	0	0	0	100	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	100	100	100	100	100	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)	0	0	0	0	0	39.00
40.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	40.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140160 Hospice CCN: 141560 | Period: From 01/01/2013 To 12/31/2013 | Worksheet K-4 Part II Date/Time Prepared: 5/22/2014 2:03 pm

Hospice I

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)		
		6A	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0			1.00
2.00	Capital Related Costs-Movable Equip.	0			2.00
3.00	Plant Operation and Maintenance	0			3.00
4.00	Transportation - Staff	0			4.00
5.00	Volunteer Service Coordination				5.00
6.00	Administrative and General	-131,185	1,483,973		6.00
	INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	0		7.00
8.00	Inpatient - Respite Care	0	0		8.00
	VISITING SERVICES				
9.00	Physician Services	0	10,575		9.00
10.00	Nursing Care	0	1,230,818		10.00
11.00	Nursing Care-Continuous Home Care	0	0		11.00
12.00	Physical Therapy	0	226		12.00
13.00	Occupational Therapy	0	0		13.00
14.00	Speech/ Language Pathology	0	0		14.00
15.00	Medical Social Services	0	4,476		15.00
16.00	Spiritual Counseling	0	1,886		16.00
17.00	Dietary Counseling	0	0		17.00
18.00	Counseling - Other	0	0		18.00
19.00	Home Health Aide and Homemaker	0	24,299		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		20.00
21.00	Other	0	0		21.00
	OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	184,695		22.00
23.00	Analgesics	0	0		23.00
24.00	Sedatives / Hypnotics	0	0		24.00
25.00	Other - Specify	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0		26.00
27.00	Patient Transportation	0	0		27.00
28.00	Imaging Services	0	0		28.00
29.00	Labs and Diagnostics	0	0		29.00
30.00	Medical Supplies	0	26,998		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		31.00
32.00	Radiation Therapy	0	0		32.00
33.00	Chemotherapy	0	0		33.00
34.00	Other	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0		35.00
36.00	Volunteer Program Costs	0	0		36.00
37.00	Fundraising	0	0		37.00
38.00	Other Program Costs	0	0		38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		131,185		39.00
40.00	Unit Cost Multiplier		0.088401		40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140160 Hospice CCN: 141560

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

Worksheet K-5 Part I Date/Time Prepared: 5/22/2014 2:03 pm

Hospice I

	Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
1.00	Administrative and General		0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	11,510	0	0	0	11,510	4.00
5.00	Nursing Care	1,339,623	0	3,832	275,211	1,618,666	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	246	0	0	0	246	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	4,872	0	0	0	4,872	10.00
11.00	Spiritual Counseling	2,053	0	0	0	2,053	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	26,447	0	0	0	26,447	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	201,022	0	0	0	201,022	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	29,385	0	0	0	29,385	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	1,615,158	0	3,832	275,211	1,894,201	34.00
35.00	Unit Cost Multiplier (see instructions)					0.000000	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140160
Hospice CCN: 141560

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

Worksheet K-5
Part I
Date/Time Prepared:
5/22/2014 2:03 pm

Hospice I

	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	3,496	0	0	0	0	4.00
5.00	Nursing Care	491,648	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	75	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	1,480	0	0	0	0	10.00
11.00	Spiritual Counseling	624	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	8,033	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	61,058	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	8,925	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	575,339	0	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140160
Hospice CCN: 141560

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

Worksheet K-5
Part I
Date/Time Prepared:
5/22/2014 2:03 pm

Hospice I

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	14,723	156,471	40,904	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	14,723	156,471	40,904	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140160
Hospice CCN: 141560

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

Worksheet K-5
Part I
Date/Time Prepared:
5/22/2014 2:03 pm

Hospice I

	Cost Center Description	Subtotal (cols. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (cols. 26 ± 27)	
		24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	0					1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	15,006	0	15,006	0	15,006	4.00
5.00	Nursing Care	2,322,412	0	2,322,412	0	2,322,412	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	321	0	321	0	321	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	6,352	0	6,352	0	6,352	10.00
11.00	Spiritual Counseling	2,677	0	2,677	0	2,677	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	34,480	0	34,480	0	34,480	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	262,080	0	262,080	0	262,080	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	38,310	0	38,310	0	38,310	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	2,681,638	0	2,681,638		2,681,638	34.00
35.00	Unit Cost Multiplier (see instructions)				0.000000		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140160
Hospice CCN: 141560

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

Worksheet K-5
Part II
Date/Time Prepared:
5/22/2014 2:03 pm

Hospice I

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	11,510	4.00
5.00	Nursing Care	0	5,583	856,949	0	1,618,666	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	246	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	4,872	10.00
11.00	Spiritual Counseling	0	0	0	0	2,053	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	26,447	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	201,022	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	29,385	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	5,583	856,949		1,894,201	34.00
35.00	Total cost to be allocated	0	3,832	275,211		575,339	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.686369	0.321152		0.303737	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140160
Hospice CCN: 141560

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

Worksheet K-5
Part II
Date/Time Prepared:
5/22/2014 2:03 pm

Hospice I

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	1,568	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	0	1,568	34.00
35.00	Total cost to be allocated	0	0	0	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140160
Hospice CCN: 141560

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

Worksheet K-5
Part II
Date/Time Prepared:
5/22/2014 2:03 pm

Hospice I

	Cost Center Description	NURSING ADMINISTRATION (DIRECT)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
		13.00	14.00	15.00	16.00		
1.00	Administrative and General	0	0	0	0		1.00
2.00	Inpatient - General Care	0	0	0	0		2.00
3.00	Inpatient - Respite Care	0	0	0	0		3.00
4.00	Physician Services	0	0	0	0		4.00
5.00	Nursing Care	0	23,471	194,123	4,772,988		5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0		6.00
7.00	Physical Therapy	0	0	0	0		7.00
8.00	Occupational Therapy	0	0	0	0		8.00
9.00	Speech/ Language Pathology	0	0	0	0		9.00
10.00	Medical Social Services	0	0	0	0		10.00
11.00	Spiritual Counseling	0	0	0	0		11.00
12.00	Dietary Counseling	0	0	0	0		12.00
13.00	Counseling - Other	0	0	0	0		13.00
14.00	Home Health Aide and Homemaker	0	0	0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00
16.00	Other	0	0	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0		17.00
18.00	Analgesics	0	0	0	0		18.00
19.00	Sedatives / Hypnotics	0	0	0	0		19.00
20.00	Other - Specify	0	0	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0		21.00
22.00	Patient Transportation	0	0	0	0		22.00
23.00	Imaging Services	0	0	0	0		23.00
24.00	Labs and Diagnostics	0	0	0	0		24.00
25.00	Medical Supplies	0	0	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0		26.00
27.00	Radiation Therapy	0	0	0	0		27.00
28.00	Chemotherapy	0	0	0	0		28.00
29.00	Other	0	0	0	0		29.00
30.00	Bereavement Program Costs	0	0	0	0		30.00
31.00	Volunteer Program Costs	0	0	0	0		31.00
32.00	Fundraising	0	0	0	0		32.00
33.00	Other Program Costs	0	0	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	23,471	194,123	4,772,988		34.00
35.00	Total cost to be allocated	0	14,723	156,471	40,904		35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.627285	0.806041	0.008570		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 140160 Hospice CCN: 141560

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

Worksheet K-5 Part III Date/Time Prepared: 5/22/2014 2:03 pm

Hospice I

	Cost Center Description	Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1.00	2.00	3.00	
	ANCILLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.347440	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00				2.00
3.00	SPEECH PATHOLOGY	68.00				3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.188679	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00
6.00	LABORATORY	60.00	0.158092	0	0	6.00
6.01	BLOOD LABORATORY	60.01				6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.155046	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00				8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00				9.00
10.00	DIABETIC EDUCATION	76.00	2.326065	0	0	10.00
11.00	Totals (sum of lines 1-10)				0	11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 140160 Hospice CCN: 141560

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

Worksheet K-6

Date/Time Prepared: 5/22/2014 2:03 pm

Hospice I

		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				2,681,638	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				13,849	2.00
3.00	Average cost per diem (line 1 divided by line 2)				193.63	3.00
4.00	Updduplicated Medicare Days (Worksheet S-9, column 1, line 5)	12,784				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	2,475,366				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		523			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		101,268			7.00
8.00	Updduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			542		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			104,947		13.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140160	Period: From 01/01/2013 To 12/31/2013	Worksheet L Parts I-III Date/Time Prepared: 5/22/2014 2:03 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,128,949	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	17,627	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)	42.38	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)	0	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	1,146,576	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