

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: 150182  
 Period: From 01/01/2013 To 12/31/2013  
 worksheet 5  
 Parts I-III  
 Date/Time Prepared: 5/28/2014 11:37 am

**PART I - COST REPORT STATUS**

Provider use only  
 1.  Electronically filed cost report  
 2.  Manually submitted cost report  
 3.  If this is an amended report enter the number of times the provider resubmitted this cost report  
 4.  Medicare utilization. Enter "F" for full or "L" for low.  
 Date: 5/28/2014 Time: 11:37 am

Contractor use only  
 5.  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.  Initial Report for this Provider CCN  
 9.  Final Report for this Provider CCN  
 10. NPR Date:  
 11. Contractor's Vendor Code: 4  
 12.  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 ST FRANCIS CARMEL ( 150182 ) 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.

**Encryption Information**

ECR: Date: 5/28/2014 Time: 11:37 am  
 Z5fLhXQn.pLnut5heJu.mjJEkKss10  
 jq1vI010H3V9n4ow:7r4Ld9dCdveOs  
 2Int0dVzsJ0:Q4B1  
 PI: Date: 5/28/2014 Time: 11:37 am  
 3Ut:INyKLtm.7ePoX0eg:8t1htdsw0  
 1858P05iw11060P:es5s:KdoTahOc.  
 HZC40Qk50b05zhGj

(Signed) *D. Pante*  
 Officer or Administrator of Provider(s)  
 title Regional CFO  
 Date 5/29/14

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	206,468	6,035	490,000	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
200.00 Total	0	206,468	6,035	490,000	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150182		Period: From 01/01/2013 To 12/31/2013		Worksheet S-2 Part I Date/Time Prepared: 5/28/2014 11:34 am						
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 12188B N. MERIDIAN STREET		PO Box:						1.00			
2.00	City: CARMEL		State: IN		Zip Code: 46032		County: MARI ON		2.00			
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)					
		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		ST FRANCIS CARMEL	150182	26900	1	06/24/2013	0	P	P	3.00	
4.00	Subprovider - IPF										4.00	
5.00	Subprovider - IRF										5.00	
6.00	Subprovider - (Other)										6.00	
7.00	Swing Beds - SNF										7.00	
8.00	Swing Beds - NF										8.00	
9.00	Hospital -Based SNF										9.00	
10.00	Hospital -Based NF										10.00	
11.00	Hospital -Based OLTC										11.00	
12.00	Hospital -Based HHA										12.00	
13.00	Separately Certified ASC										13.00	
14.00	Hospital -Based Hospice										14.00	
15.00	Hospital -Based Health Clinic - RHC										15.00	
16.00	Hospital -Based Health Clinic - FQHC										16.00	
17.00	Hospital -Based (CMHC) I										17.00	
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)					1			21.00			
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N			22.00			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N		N	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.					0			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 days	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.					0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.					0	0	0	0	0	0	25.00
						Urban/Rural	S	Date of Geogr				
						1.00	2.00					
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1			26.00			
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1			27.00			
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00			

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		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00
		V 1.00	XVIII 2.00	XIX 3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
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	Y	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
<b>Teaching Hospitals</b>						
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.	N				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 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/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 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 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

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	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
	1.00	2.00	3.00	4.00		
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.		0.00	0.00	61.20	
				1.00		
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)			0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)			0.00	62.01	
<u>Teaching Hospitals that Claim Residents in Non-Provider Settings</u>						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)			N	63.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
64.00	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. 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	
<u>Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010</u>						
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

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	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
<b>Inpatient Psychiatric Facility PPS</b>							
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)			N		0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>							
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)			N		0	76.00
					1.00		
<b>Long Term Care Hospital PPS</b>							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N	80.00
<b>TEFRA Providers</b>							
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	
<b>Title V and XIX Services</b>							
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		Y	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		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		97.00
<b>Rural Providers</b>							
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)	N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
		1.00	2.00	3.00	
<b>Miscellaneous Cost Reporting Information</b>					
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
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		N		
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		0		
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		
119.00	DO NOT USE THIS LINE				
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N		N
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		
<b>Transplant Center Information</b>					
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		
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.				
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.				
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.				
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.				
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.				
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.				
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.				
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.				
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.				
<b>All Providers</b>					
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	158014	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150182	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/28/2014 11:34 am			
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: FRANCISCAN ALLIANCE, INC. AND AFFILI	Contractor's Name: WISONSIN PHYSICIAN SERVICES		Contractor's Number: 08101			
142.00	Street: 1515 W DRAGON TRAIL	PO Box: 1290					
143.00	City: MISHAWKA	State: IN		Zip Code: 46544			
				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			
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00	
		Name	County	State	Zip Code	CBSA	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
				1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.				Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					1.00	
				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)			07/01/2013	09/30/2013		170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150182	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/28/2014 11:34 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/02/2014	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150182	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/28/2014 11:34 am	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
<b>Cost Report Preparer Contact Information</b>					
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.	BKD		BKD	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	502.581.0435		LV COSTREPORTS@BKD.COM	43.00

		Part B	
		Date	
		4.00	
<b>PS&amp;R Data</b>			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	05/02/2014	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
<b>Cost Report Preparer Contact Information</b>			
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.	BKD	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: 150182

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/28/2014 11:34 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	6	2,190	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)		6	2,190	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		6	2,190	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		6				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: 150182

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/28/2014 11:34 am

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)	52	3	211			1.00
2.00 HMO and other (see instructions)	0	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	52	3	211			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)	52	3	211	0.00	36.84	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	36.84	27.00
28.00 Observation Bed Days		1	20			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150182

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/28/2014 11:34 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	22	1	104	1.00
2.00 HMO and other (see instructions)				0			2.00
3.00 HMO IPF Subprovider							3.00
4.00 HMO IRF Subprovider							4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0	22	1		104	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 150182	Period: From 01/01/2013 To 12/31/2013	Worksheet S-3 Part II Date/Time Prepared: 5/28/2014 11:34 am
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	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	2,357,568	0	2,357,568	76,633.93	30.76
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract labor (see instructions)		5,146	0	5,146	147.42	34.91
12.00	Contract management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		129,985	0	129,985	679.57	191.28
14.00	Home office salaries & wage-related costs		1,114,346	0	1,114,346	26,453.84	42.12
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		6,903,770	0	6,903,770		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		0	0	0		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FOHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00
27.00	Administrative & General	5.00	109,629	0	109,629	7,169.06	15.29
28.00	Administrative & General under contract (see inst.)		33,285	0	33,285	409.05	81.37
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	53,347	0	53,347	2,061.00	25.88
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	260,633	-6,736	253,897	9,938.84	25.55
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	6,736	6,736	264.00	25.52
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	0	0	0	0.00	0.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00
40.00	Pharmacy	15.00	170,539	0	170,539	4,055.65	42.05
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150182

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/28/2014 11:34 am

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

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150182

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/28/2014 11:34 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	2,390,853	0	2,390,853	77,042.98	31.03	1.00
2.00	Excluded area salaries (see instructions)	0	0	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	2,390,853	0	2,390,853	77,042.98	31.03	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,249,477	0	1,249,477	27,280.83	45.80	4.00
5.00	Subtotal wage-related costs (see inst.)	6,903,770	0	6,903,770	0.00	288.76	5.00
6.00	Total (sum of lines 3 thru 5)	10,544,100	0	10,544,100	104,323.81	101.07	6.00
7.00	Total overhead cost (see instructions)	627,433	0	627,433	23,897.60	26.26	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 150182	Period: From 01/01/2013 To 12/31/2013	Worksheet S-3 Part IV Date/Time Prepared: 5/28/2014 11:34 am
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		Amount Reported	
		1.00	
<b>PART IV - WAGE RELATED COSTS</b>			
<b>Part A - Core List</b>			
<b>RETIREMENT COST</b>			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	162,962	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1,738,027	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
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
<b>HEALTH AND INSURANCE COST</b>			
8.00	Health Insurance (Purchased or Self Funded)	3,034,097	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	128,239	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	58,884	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	163,906	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
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	1,589,938	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	18,917	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
<b>OTHER</b>			
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	8,800	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,903,770	24.00
<b>Part B - Other than Core Related Cost</b>			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150182

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

Worksheet S-3  
Part V  
Date/Time Prepared:  
5/28/2014 11:34 am

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150182	Period: From 01/01/2013 To 12/31/2013	Worksheet S-10 Date/Time Prepared: 5/28/2014 11:34 am
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			1.00	
<b>Uncompensated and indigent care cost computation</b>				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.568686	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		100,898	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		575,264	6.00
7.00	Medicaid cost (line 1 times line 6)		327,145	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)		226,247	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone SCHIP		0	9.00
10.00	Stand-alone SCHIP charges		0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Uncompensated care (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		226,247	19.00
			1.00	
			2.00	
			3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	252,943	0	252,943
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	143,845	0	143,845
22.00	Partial payment by patients approved for charity care	2,782	0	2,782
23.00	Cost of charity care (line 21 minus line 22)	141,063	0	141,063
			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)		68,878	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		4,135	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		64,743	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		36,818	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		177,881	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		404,128	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 150182		Period: From 01/01/2013 To 12/31/2013		Worksheet A	
Date/Time Prepared: 5/28/2014 11:34 am							
Cost Center	Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		954,748	954,748	2,261,396	3,216,144	1.00
2.00	00200		1,683,474	1,683,474	305,219	1,988,693	2.00
4.00	00400		0	0	786,939	786,939	4.00
5.01	00540	75,120	29,975	105,095	-25,176	79,919	5.01
5.02	00550	0	0	0	0	0	5.02
5.03	00560	34,509	123,176	157,685	-11,583	146,102	5.03
7.00	00700	53,347	2,090,607	2,143,954	-2,029,020	114,934	7.00
8.00	00800	0	25,366	25,366	0	25,366	8.00
9.00	00900	0	149,464	149,464	-1,641	147,823	9.00
10.00	01000	260,633	87,404	348,037	-95,986	252,051	10.00
11.00	01100	0	0	0	8,995	8,995	11.00
13.00	01300	0	0	0	0	0	13.00
14.00	01400	0	59,467	59,467	-42,339	17,128	14.00
15.00	01500	170,539	1,179,966	1,350,505	-1,167,677	182,828	15.00
16.00	01600	0	0	0	0	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	286,999	127,744	414,743	-101,878	312,865	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	877,267	2,155,790	3,033,057	-1,879,234	1,153,823	50.00
54.00	05400	291,141	654,410	945,551	-464,537	481,014	54.00
60.00	06000	0	399,437	399,437	-30,213	369,224	60.00
64.00	06400	0	310,651	310,651	-7,596	303,055	64.00
65.00	06500	126,853	43,928	170,781	-43,911	126,870	65.00
66.00	06600	181,160	70,495	251,655	-63,255	188,400	66.00
69.00	06900	0	10,106	10,106	0	10,106	69.00
71.00	07100	0	0	0	575,962	575,962	71.00
72.00	07200	0	0	0	1,016,530	1,016,530	72.00
73.00	07300	0	0	0	1,086,796	1,086,796	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	0	77,603	77,603	-77,603	0	113.00
118.00		2,357,568	10,233,811	12,591,379	188	12,591,567	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	4,030	4,030	0	4,030	190.00
192.00	19200	0	770	770	-188	582	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07952	0	0	0	0	0	194.01
200.00		2,357,568	10,238,611	12,596,179	0	12,596,179	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150182

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

Worksheet A  
Date/Time Prepared:  
5/28/2014 11:34 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-507,495	2,708,649	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,988,693	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	21,150	808,089	4.00
5.01	00540	ADMINISTRATIVE	37,395	117,314	5.01
5.02	00550	CASHIERING/ACCOUNTS RECEIVABLE	208,370	208,370	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	1,809,913	1,956,015	5.03
7.00	00700	OPERATION OF PLANT	-8	114,926	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	25,366	8.00
9.00	00900	HOUSEKEEPING	0	147,823	9.00
10.00	01000	DIETARY	0	252,051	10.00
11.00	01100	CAFETERIA	0	8,995	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	17,128	14.00
15.00	01500	PHARMACY	0	182,828	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	41,081	41,081	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-15,000	297,865	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-26,057	1,127,766	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-30,676	450,338	54.00
60.00	06000	LABORATORY	1,004	370,228	60.00
64.00	06400	INTRAVENOUS THERAPY	-4,274	298,781	64.00
65.00	06500	RESPIRATORY THERAPY	0	126,870	65.00
66.00	06600	PHYSICAL THERAPY	0	188,400	66.00
69.00	06900	ELECTROCARDIOLOGY	0	10,106	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-3,483	572,479	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,016,530	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-11,279	1,075,517	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,520,641	14,112,208	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,030	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	582	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	MARKETING & COMMUNITY RELATIONS	194,352	194,352	194.00
194.01	07952	OTHER NONREIMBURSABLE	31,274	31,274	194.01
200.00		TOTAL (SUM OF LINES 118-199)	1,746,267	14,342,446	200.00

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
<b>A - MEDICAL SUPPLIES</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	575,962	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,016,530	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
	<b>TOTALS</b>		0	1,592,492	
<b>B - DRUGS</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,086,796	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	<b>TOTALS</b>		0	1,086,796	
<b>C - CAPITAL EXPENSE</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,183,793	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	30,213	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	275,006	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	<b>TOTALS</b>		0	2,489,012	
<b>D - EMPLOYEE BENEFITS</b>					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	786,939	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
	<b>TOTALS</b>		0	786,939	
<b>E - CAFETERIA</b>					
1.00	CAFETERIA	11.00	6,736	2,259	1.00
	<b>TOTALS</b>		6,736	2,259	
<b>F - INTEREST EXPENSE</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	77,603	1.00
	<b>TOTALS</b>		0	77,603	
500.00	<b>Grand Total: Increases</b>		6,736	6,035,101	500.00

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
<b>A - MEDICAL SUPPLIES</b>							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	153	0		1.00
2.00	OPERATION OF PLANT	7.00	0	158	0		2.00
3.00	HOUSEKEEPING	9.00	0	1,641	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	42,339	0		4.00
5.00	PHARMACY	15.00	0	4,713	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	5,914	0		6.00
7.00	OPERATING ROOM	50.00	0	1,526,023	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,864	0		8.00
9.00	INTRAVENOUS THERAPY	64.00	0	4,601	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	1,577	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	2,509	0		11.00
	<b>TOTALS</b>		0	1,592,492			
<b>B - DRUGS</b>							
1.00	PHARMACY	15.00	0	1,068,104	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	190	0		2.00
3.00	OPERATING ROOM	50.00	0	15,236	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	109	0		4.00
5.00	INTRAVENOUS THERAPY	64.00	0	2,995	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	162	0		6.00
	<b>TOTALS</b>		0	1,086,796			
<b>C - CAPITAL EXPENSE</b>							
1.00	OPERATION OF PLANT	7.00	0	2,011,097	10		1.00
2.00	PHARMACY	15.00	0	37,862	9		2.00
3.00	OPERATING ROOM	50.00	0	45,132	10		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	364,708	0		4.00
5.00	LABORATORY	60.00	0	30,213	0		5.00
	<b>TOTALS</b>		0	2,489,012			
<b>D - EMPLOYEE BENEFITS</b>							
1.00	ADMINISTRATIVE	5.01	0	25,176	0		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	11,430	0		2.00
3.00	OPERATION OF PLANT	7.00	0	17,765	0		3.00
4.00	DIETARY	10.00	0	86,991	0		4.00
5.00	PHARMACY	15.00	0	56,998	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	95,774	0		6.00
7.00	OPERATING ROOM	50.00	0	292,843	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	96,856	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	42,334	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	60,584	0		10.00
11.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	188	0		11.00
	<b>TOTALS</b>		0	786,939			
<b>E - CAFETERIA</b>							
1.00	DIETARY	10.00	6,736	2,259	0		1.00
	<b>TOTALS</b>		6,736	2,259			
<b>F - INTEREST EXPENSE</b>							
1.00	INTEREST EXPENSE	113.00	0	77,603	11		1.00
	<b>TOTALS</b>		0	77,603			
500.00	<b>Grand Total: Decreases</b>		6,736	6,035,101			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150182

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/28/2014 11:34 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	175,842	8,810,063	0	8,810,063	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	6,585,797	1,935,289	0	1,935,289	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	6,761,639	10,745,352	0	10,745,352	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	6,761,639	10,745,352	0	10,745,352	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	0	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	8,985,905	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	8,521,086	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	17,506,991	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	17,506,991	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150182

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/28/2014 11:34 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	954,748	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,683,474	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,638,222	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	954,748				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,683,474				2.00
3.00	Total (sum of lines 1-2)	0	2,638,222				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150182

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/28/2014 11:34 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	8,985,905	0	8,985,905	0.513275	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,521,086	0	8,521,086	0.486725	0	2.00
3.00	Total (sum of lines 1-2)	17,506,991	0	17,506,991	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of col.s. 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	954,748	1,752,865	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,713,687	275,006	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,668,435	2,027,871	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of col.s. 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	1,036	0	0	0	2,708,649	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,988,693	2.00
3.00	Total (sum of lines 1-2)	1,036	0	0	0	4,697,342	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150182

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

Worksheet A-8

Date/Time Prepared:  
5/28/2014 11:34 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
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)	B	-3,146	0	OTHER ADMINISTRATIVE AND GENERAL	5.03	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	-123,464	0			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	2,330,072	0			0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests			0		0.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts			0		0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	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 Physician's 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 RENTAL REVENUE	B	-430,928	0	CAP REL COSTS-BLDG & FIXT	1.00	10	33.00

Provider CCN: 150182	Period: From 01/01/2013 To 12/31/2013	Worksheet A-8 Date/Time Prepared: 5/28/2014 11:34 am
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
33.01 MISCELLANEOUS REVENUE - INFUSION THE	B	-4,274	INTRAVENOUS THERAPY	64.00	0	33.01
33.02 DISCOUNTS - OPERATING ROOM	B	-6,665	OPERATING ROOM	50.00	0	33.02
33.03 DISCOUNTS - SUPPLIES	B	-3,483	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.03
33.04 DISCOUNTS - LAB	B	-101	LABORATORY	60.00	0	33.04
33.05 DISCOUNTS - PHARMACY	B	-11,279	DRUGS CHARGED TO PATIENTS	73.00	0	33.05
33.06 DISCOUNTS - ENGINEERING	B	-8	OPERATION OF PLANT	7.00	0	33.06
33.07 ADVERTISING	A	-457	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.07
33.08		0		0.00	0	33.08
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,746,267				50.00

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

Provider CCN: 150182

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

Worksheet A-8-1

Date/Time Prepared: 5/28/2014 11:34 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED SERVICES	21,150	0
2.00	5.01	ADMINISTRATIVE	SHARED SERVICES	37,395	0
3.00	5.02	CASHIERING/ACCOUNTS RECEIVABLE	SHARED SERVICES	208,370	0
4.00	5.03	OTHER ADMINISTRATIVE AND GENERAL	SHARED SERVICES	719,403	0
4.01	16.00	MEDICAL RECORDS & LIBRARY	SHARED SERVICES	41,081	0
4.02	194.00	MARKETING & COMMUNITY RELATIONS	SHARED SERVICES	194,352	0
4.03	194.01	OTHER NONREIMBURSABLE	SHARED SERVICES	31,274	0
4.04	1.00	CAP REL COSTS-BLDG & FIXTURES	FRANCISCAN HOME OFFICE	1,036	77,603
4.05	5.03	OTHER ADMINISTRATIVE AND GENERAL	FRANCISCAN HOME OFFICE	146,893	0
4.06	5.03	OTHER ADMINISTRATIVE AND GENERAL	FRANCISCAN HOME OFFICE	1,005,616	0
4.07	60.00	LABORATORY	APHL SHARED LAB EXPENSE	332,637	331,532
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,739,207	409,135

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

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

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

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

6.00	B	0.00	APHL	100.00	6.00
7.00	B	0.00	FRANCISCAN	100.00	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: 150182

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

Worksheet A-8-1

Date/Time Prepared:  
5/28/2014 11:34 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	21,150	0		1.00
2.00	37,395	0		2.00
3.00	208,370	0		3.00
4.00	719,403	0		4.00
4.01	41,081	0		4.01
4.02	194,352	0		4.02
4.03	31,274	0		4.03
4.04	-76,567	11		4.04
4.05	146,893	0		4.05
4.06	1,005,616	0		4.06
4.07	1,105	0		4.07
5.00	2,330,072			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	SHARED LAB		6.00
7.00	COMMONLY OWNED		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: 150182

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

Worksheet A-8-2

Date/Time Prepared:  
5/28/2014 11:34 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.03	OTHER ADMINISTRATIVE AND GENERAL	95,710	30,000	65,710	177,200	438	1.00
2.00	30.00	ADULTS & PEDIATRICS	15,000	15,000	0	177,200	0	2.00
3.00	50.00	OPERATING ROOM	37,292	10,517	26,775	208,000	179	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	37,500	0	37,500	225,300	63	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			185,502	55,517	129,985		680	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	5.03	OTHER ADMINISTRATIVE AND GENERAL	37,314	1,866	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	17,900	895	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	6,824	341	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			62,038	3,102	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	5.03	OTHER ADMINISTRATIVE AND GENERAL	0	37,314	28,396	58,396		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	15,000		2.00
3.00	50.00	OPERATING ROOM	0	17,900	8,875	19,392		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	6,824	30,676	30,676		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	62,038	67,947	123,464		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150182

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/28/2014 11:34 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,708,649	2,708,649			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,988,693		1,988,693		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	808,089	0	0	808,089	4.00
5.01 00540	ADMITTING	117,314	42,898	31,496	25,748	217,456 5.01
5.02 00550	CASHIERING/ACCOUNTS RECEIVABLE	208,370	11,081	8,136	0	0 5.02
5.03 00560	OTHER ADMINISTRATIVE AND GENERAL	1,956,015	38,998	28,632	11,828	0 5.03
7.00 00700	OPERATION OF PLANT	114,926	90,789	66,658	18,285	0 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	25,366	0	0	0	0 8.00
9.00 00900	HOUSEKEEPING	147,823	50,983	37,432	0	0 9.00
10.00 01000	DIETARY	252,051	10,701	7,856	87,027	0 10.00
11.00 01100	CAFETERIA	8,995	0	0	2,309	0 11.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	0 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	17,128	67,390	49,478	0	0 14.00
15.00 01500	PHARMACY	182,828	68,199	50,072	58,455	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	41,081	0	0	0	0 16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	297,865	125,127	91,868	98,373	15,112 30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	1,127,766	676,093	496,387	300,695	53,718 50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	450,338	145,529	106,848	99,793	719 54.00
60.00 06000	LABORATORY	370,228	34,575	25,385	0	5,729 60.00
64.00 06400	INTRAVENOUS THERAPY	298,781	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	126,870	0	0	43,481	5,931 65.00
66.00 06600	PHYSICAL THERAPY	188,400	187,856	137,924	62,095	6,938 66.00
69.00 06900	ELECTROCARDIOLOGY	10,106	264,758	194,386	0	79 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	572,479	0	0	0	27,667 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	1,016,530	0	0	0	87,728 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,075,517	0	0	0	13,835 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100	EMERGENCY	0	0	0	0	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	14,112,208	1,814,977	1,332,558	808,089	217,456 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,030	0	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	582	251,822	184,888	0	0 192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
194.00 07950	MARKETING & COMMUNITY RELATIONS	194,352	0	0	0	0 194.00
194.01 07952	OTHER NONREIMBURSABLE	31,274	641,850	471,247	0	0 194.01
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	14,342,446	2,708,649	1,988,693	808,089	217,456 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150182

Period:  
From 01/01/2013  
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Cost Center Description		Subtotal	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	
		5A.01	5.02	5A.02	5.03	7.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550	227,587	227,587				5.02
5.03	00560	2,035,473	32,820	2,068,293	2,068,293		5.03
7.00	00700	290,658	4,687	295,345	49,768	345,113	7.00
8.00	00800	25,366	409	25,775	4,343	0	8.00
9.00	00900	236,238	3,809	240,047	40,450	6,969	9.00
10.00	01000	357,635	5,767	363,402	61,236	1,463	10.00
11.00	01100	11,304	182	11,486	1,935	0	11.00
13.00	01300	0	0	0	0	0	13.00
14.00	01400	133,996	2,161	136,157	22,944	9,211	14.00
15.00	01500	359,554	5,797	365,351	61,565	9,322	15.00
16.00	01600	41,081	662	41,743	7,034	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	628,345	10,131	638,476	107,588	17,103	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	2,654,659	42,802	2,697,461	454,543	92,411	50.00
54.00	05400	803,227	12,951	816,178	137,533	19,892	54.00
60.00	06000	435,917	7,029	442,946	74,640	4,726	60.00
64.00	06400	298,781	4,818	303,599	51,159	0	64.00
65.00	06500	176,282	2,842	179,124	30,184	0	65.00
66.00	06600	583,213	9,404	592,617	99,861	25,677	66.00
69.00	06900	469,329	7,567	476,896	80,361	36,188	69.00
71.00	07100	600,146	9,677	609,823	102,760	0	71.00
72.00	07200	1,104,258	17,805	1,122,063	189,077	0	72.00
73.00	07300	1,089,352	17,565	1,106,917	186,524	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		12,562,401	198,885	12,533,699	1,763,505	222,962	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	4,030	65	4,095	690	0	190.00
192.00	19200	437,292	7,051	444,343	74,875	34,420	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	194,352	3,134	197,486	33,278	0	194.00
194.01	07952	1,144,371	18,452	1,162,823	195,945	87,731	194.01
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		14,342,446	227,587	14,342,446	2,068,293	345,113	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150182

Period:  
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Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
7.00	00700						7.00
8.00	00800	30,118					8.00
9.00	00900	0	287,466				9.00
10.00	01000	0	1,243	427,344			10.00
11.00	01100	0	0	0	13,421		11.00
13.00	01300	0	0	0	0	0	13.00
14.00	01400	0	7,831	0	0	0	14.00
15.00	01500	0	7,925	0	952	0	15.00
16.00	01600	0	0	0	0	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	14,540	427,344	1,476	0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	25,053	78,560	0	6,438	0	50.00
54.00	05400	2,666	16,910	0	2,174	0	54.00
60.00	06000	0	4,018	0	0	0	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	0	939	0	65.00
66.00	06600	2,399	21,829	0	1,442	0	66.00
69.00	06900	0	30,765	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	0	0	0	0	0	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		30,118	183,621	427,344	13,421	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	29,262	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07952	0	74,583	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		30,118	287,466	427,344	13,421	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150182

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

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Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	15.00	16.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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
5.01	00540	ADMITTING					5.01
5.02	00550	CASHIERING/ACCOUNTS RECEIVABLE					5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL					5.03
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	176,143				14.00
15.00	01500	PHARMACY	233	445,348			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	48,777		16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	62	0	729	1,207,318	0 30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	14,110	0	11,319	3,379,895	0 50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	357	0	2,644	998,354	0 54.00
60.00	06000	LABORATORY	0	0	2,438	528,768	0 60.00
64.00	06400	INTRAVENOUS THERAPY	246	0	617	355,621	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	0	512	210,759	0 65.00
66.00	06600	PHYSICAL THERAPY	95	0	1,057	744,977	0 66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	17	624,227	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	58,093	0	4,779	775,455	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	102,947	0	5,416	1,419,503	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	445,348	19,249	1,758,038	0 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
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
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	176,143	445,348	48,777	12,002,915	0 118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	4,785	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	582,900	0 192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0 193.00
194.00	07950	MARKETING & COMMUNITY RELATIONS	0	0	0	230,764	0 194.00
194.01	07952	OTHER NONREIMBURSABLE	0	0	0	1,521,082	0 194.01
200.00		Cross Foot Adjustments				0	0 200.00
201.00		Negative Cost Centers	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118-201)	176,143	445,348	48,777	14,342,446	0 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150182

Period:  
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Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
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
5.01	00540	ADMITTING	5.01
5.02	00550	CASHIERING/ACCOUNTS RECEIVABLE	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	5.03
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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000	OPERATING ROOM	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
194.00	07950	MARKETING & COMMUNITY RELATIONS	194.00
194.01	07952	OTHER NONREIMBURSABLE	194.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150182

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

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
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	0	0	0	4.00
5.01 00540	ADMINISTRATIVE	0	42,898	31,496	74,394	5.01
5.02 00550	CASHIERING/ACCOUNTS RECEIVABLE	0	11,081	8,136	19,217	5.02
5.03 00560	OTHER ADMINISTRATIVE AND GENERAL	146,893	38,998	28,632	214,523	5.03
7.00 00700	OPERATION OF PLANT	0	90,789	66,658	157,447	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	50,983	37,432	88,415	9.00
10.00 01000	DIETARY	0	10,701	7,856	18,557	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	67,390	49,478	116,868	14.00
15.00 01500	PHARMACY	0	68,199	50,072	118,271	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	125,127	91,868	216,995	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	676,093	496,387	1,172,480	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	145,529	106,848	252,377	54.00
60.00 06000	LABORATORY	0	34,575	25,385	59,960	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	187,856	137,924	325,780	66.00
69.00 06900	ELECTROCARDIOLOGY	0	264,758	194,386	459,144	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100	EMERGENCY	0	0	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	146,893	1,814,977	1,332,558	3,294,428	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	251,822	184,888	436,710	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	MARKETING & COMMUNITY RELATIONS	0	0	0	0	194.00
194.01 07952	OTHER NONREIMBURSABLE	0	641,850	471,247	1,113,097	194.01
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	146,893	2,708,649	1,988,693	4,844,235	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150182		Period: From 01/01/2013 To 12/31/2013		Worksheet B Part II Date/Time Prepared: 5/28/2014 11:34 am	
Cost Center Description		ADMINITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5.01	5.02	5.03	7.00	8.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540	74,394					5.01
5.02	00550		19,217				5.02
5.03	00560		2,770	217,293			5.03
7.00	00700		396	5,228	163,071		7.00
8.00	00800		35	456	0	491	8.00
9.00	00900		322	4,250	3,293	0	9.00
10.00	01000		487	6,433	691	0	10.00
11.00	01100		15	203	0	0	11.00
13.00	01300		0	0	0	0	13.00
14.00	01400		182	2,410	4,352	0	14.00
15.00	01500		489	6,468	4,405	0	15.00
16.00	01600		56	739	0	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	5,170	855	11,303	8,081	0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	18,377	3,619	47,759	43,666	409	50.00
54.00	05400	246	1,093	14,449	9,399	43	54.00
60.00	06000	1,960	593	7,841	2,233	0	60.00
64.00	06400	0	407	5,375	0	0	64.00
65.00	06500	2,029	240	3,171	0	0	65.00
66.00	06600	2,374	794	10,491	12,133	39	66.00
69.00	06900	27	639	8,442	17,100	0	69.00
71.00	07100	9,465	817	10,796	0	0	71.00
72.00	07200	30,013	1,503	19,864	0	0	72.00
73.00	07300	4,733	1,483	19,596	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	0	0	0	0	0	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		74,394	16,795	185,274	105,353	491	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	5	72	0	0	190.00
192.00	19200	0	595	7,866	16,264	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	265	3,496	0	0	194.00
194.01	07952	0	1,557	20,585	41,454	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		74,394	19,217	217,293	163,071	491	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150182

Period:  
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To 12/31/2013

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Part II  
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Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	96,280					9.00
10.00	01000	416	26,584				10.00
11.00	01100	0	0	218			11.00
13.00	01300	0	0	0	0		13.00
14.00	01400	2,623	0	0	0	126,435	14.00
15.00	01500	2,654	0	15	0	167	15.00
16.00	01600	0	0	0	0	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	4,870	26,584	24	0	45	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	26,311	0	106	0	10,128	50.00
54.00	05400	5,664	0	35	0	256	54.00
60.00	06000	1,346	0	0	0	0	60.00
64.00	06400	0	0	0	0	176	64.00
65.00	06500	0	0	15	0	0	65.00
66.00	06600	7,311	0	23	0	68	66.00
69.00	06900	10,304	0	0	0	0	69.00
71.00	07100	0	0	0	0	41,699	71.00
72.00	07200	0	0	0	0	73,896	72.00
73.00	07300	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	0	0	0	0	0	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		61,499	26,584	218	0	126,435	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	9,801	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07952	24,980	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		96,280	26,584	218	0	126,435	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCN: 150182		Period: From 01/01/2013 To 12/31/2013		Worksheet B Part II Date/Time Prepared: 5/28/2014 11:34 am	
Cost Center	Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		15.00	16.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500	132,469					15.00
16.00	01600	0	795				16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	12	273,939	0	273,939	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	186	1,323,041	0	1,323,041	50.00
54.00	05400	0	43	283,605	0	283,605	54.00
60.00	06000	0	40	73,973	0	73,973	60.00
64.00	06400	0	10	5,968	0	5,968	64.00
65.00	06500	0	8	5,463	0	5,463	65.00
66.00	06600	0	17	359,030	0	359,030	66.00
69.00	06900	0	0	495,656	0	495,656	69.00
71.00	07100	0	79	62,856	0	62,856	71.00
72.00	07200	0	89	125,365	0	125,365	72.00
73.00	07300	132,469	311	158,592	0	158,592	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		132,469	795	3,167,488	0	3,167,488	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	77	0	77	190.00
192.00	19200	0	0	471,236	0	471,236	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	3,761	0	3,761	194.00
194.01	07952	0	0	1,201,673	0	1,201,673	194.01
200.00				0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		132,469	795	4,844,235	0	4,844,235	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150182

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

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (IP CHARGES)	Reconciliation	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	56,954				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		56,954			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	2,357,568		4.00
5.01 00540	ADMITTING	902	902	75,120	4,101,754	5.01
5.02 00550	CASHIERING/ACCOUNTS RECEIVABLE	233	233	0	0	-227,587
5.03 00560	OTHER ADMINISTRATIVE AND GENERAL	820	820	34,509	0	0
7.00 00700	OPERATION OF PLANT	1,909	1,909	53,347	0	0
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0
9.00 00900	HOUSEKEEPING	1,072	1,072	0	0	0
10.00 01000	DIETARY	225	225	253,897	0	0
11.00 01100	CAFETERIA	0	0	6,736	0	0
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	0
14.00 01400	CENTRAL SERVICES & SUPPLY	1,417	1,417	0	0	0
15.00 01500	PHARMACY	1,434	1,434	170,539	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	2,631	2,631	286,999	285,049	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	14,216	14,216	877,267	1,013,254	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,060	3,060	291,141	13,570	0
60.00 06000	LABORATORY	727	727	0	108,073	0
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	0	0	126,853	111,872	0
66.00 06600	PHYSICAL THERAPY	3,950	3,950	181,160	130,877	0
69.00 06900	ELECTROCARDIOLOGY	5,567	5,567	0	1,499	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	521,878	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,654,724	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	260,958	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100	EMERGENCY	0	0	0	0	0
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	38,163	38,163	2,357,568	4,101,754	-227,587
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	5,295	5,295	0	0	0
193.00 19300	NONPAID WORKERS	0	0	0	0	0
194.00 07950	MARKETING & COMMUNITY RELATIONS	0	0	0	0	0
194.01 07952	OTHER NONREIMBURSABLE	13,496	13,496	0	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	2,708,649	1,988,693	808,089	217,456	
203.00	Unit cost multiplier (Wkst. B, Part I)	47.558538	34.917530	0.342764	0.053015	
204.00	Cost to be allocated (per Wkst. B, Part II)			0	74,394	
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000	0.018137	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150182

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

Worksheet B-1  
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Cost Center Description		CASHIERING/ACCOUNTS RECEIVABLE (ACCUM. COST)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)		
		5.02	5A.03	5.03	7.00	8.00		
<b>GENERAL SERVICE COST CENTERS</b>								
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	
5.01	00540	ADMINITTING					5.01	
5.02	00550	CASHIERING/ACCOUNTS RECEIVABLE	14,114,859				5.02	
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	2,035,473	-2,068,293	12,274,153		5.03	
7.00	00700	OPERATION OF PLANT	290,658	0	295,345	53,090	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	25,366	0	25,775	0	8.00	
9.00	00900	HOUSEKEEPING	236,238	0	240,047	1,072	9.00	
10.00	01000	DIETARY	357,635	0	363,402	225	10.00	
11.00	01100	CAFETERIA	11,304	0	11,486	0	11.00	
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	133,996	0	136,157	1,417	14.00	
15.00	01500	PHARMACY	359,554	0	365,351	1,434	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	41,081	0	41,743	0	16.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	628,345	0	638,476	2,631	30.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	2,654,659	0	2,697,461	14,216	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	803,227	0	816,178	3,060	54.00	
60.00	06000	LABORATORY	435,917	0	442,946	727	60.00	
64.00	06400	INTRAVENOUS THERAPY	298,781	0	303,599	0	64.00	
65.00	06500	RESPIRATORY THERAPY	176,282	0	179,124	0	65.00	
66.00	06600	PHYSICAL THERAPY	583,213	0	592,617	3,950	66.00	
69.00	06900	ELECTROCARDIOLOGY	469,329	0	476,896	5,567	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	600,146	0	609,823	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,104,258	0	1,122,063	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1,089,352	0	1,106,917	0	73.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00	
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE					113.00	
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,334,814	-2,068,293	10,465,406	34,299	22,007	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,030	0	4,095	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	437,292	0	444,343	5,295	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING & COMMUNITY RELATIONS	194,352	0	197,486	0	0	194.00
194.01	07952	OTHER NONREIMBURSABLE	1,144,371	0	1,162,823	13,496	0	194.01
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)	227,587		2,068,293	345,113	30,118	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.016124		0.168508	6.500527	1.368565	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	19,217		217,293	163,071	491	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001361		0.017703	3.071595	0.022311	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150182

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

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description		HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (TOTAL PATIENT DAYS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	52,018					9.00
10.00	01000	225	211				10.00
11.00	01100	0	0	57,202			11.00
13.00	01300	0	0	0	0		13.00
14.00	01400	1,417	0	0	0	1,739,296	14.00
15.00	01500	1,434	0	4,056	0	2,304	15.00
16.00	01600	0	0	0	0	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	2,631	211	6,289	0	614	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	14,216	0	27,444	0	139,331	50.00
54.00	05400	3,060	0	9,267	0	3,526	54.00
60.00	06000	727	0	0	0	0	60.00
64.00	06400	0	0	0	0	2,426	64.00
65.00	06500	0	0	4,000	0	0	65.00
66.00	06600	3,950	0	6,146	0	939	66.00
69.00	06900	5,567	0	0	0	0	69.00
71.00	07100	0	0	0	0	573,626	71.00
72.00	07200	0	0	0	0	1,016,530	72.00
73.00	07300	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	0	0	0	0	0	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		33,227	211	57,202	0	1,739,296	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	5,295	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07952	13,496	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		287,466	427,344	13,421	0	176,143	202.00
203.00		5.526279	2,025.327014	0.234625	0.000000	0.101273	203.00
204.00		96,280	26,584	218	0	126,435	204.00
205.00		1.850898	125.990521	0.003811	0.000000	0.072693	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150182

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

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description		PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100			1.00
2.00	00200			2.00
4.00	00400			4.00
5.01	00540			5.01
5.02	00550			5.02
5.03	00560			5.03
7.00	00700			7.00
8.00	00800			8.00
9.00	00900			9.00
10.00	01000			10.00
11.00	01100			11.00
13.00	01300			13.00
14.00	01400			14.00
15.00	01500	1,000		15.00
16.00	01600	0	21,106,415	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	0	315,294	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	0	4,897,802	50.00
54.00	05400	0	1,143,984	54.00
60.00	06000	0	1,054,869	60.00
64.00	06400	0	266,938	64.00
65.00	06500	0	221,352	65.00
66.00	06600	0	457,295	66.00
69.00	06900	0	7,250	69.00
71.00	07100	0	2,068,143	71.00
72.00	07200	0	2,343,412	72.00
73.00	07300	1,000	8,330,076	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00	09100	0	0	91.00
92.00	09200			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300			113.00
118.00		1,000	21,106,415	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	0	0	190.00
192.00	19200	0	0	192.00
193.00	19300	0	0	193.00
194.00	07950	0	0	194.00
194.01	07952	0	0	194.01
200.00				200.00
201.00				201.00
202.00		445,348	48,777	202.00
203.00		445.348000	0.002311	203.00
204.00		132,469	795	204.00
205.00		132.469000	0.000038	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150182

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

Worksheet C  
Part I  
Date/Time Prepared:  
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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	1,207,318		1,207,318	0	1,207,318	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	3,379,895		3,379,895	8,875	3,388,770	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	998,354		998,354	30,676	1,029,030	54.00
60.00	06000 LABORATORY	528,768		528,768	0	528,768	60.00
64.00	06400 INTRAVENOUS THERAPY	355,621		355,621	0	355,621	64.00
65.00	06500 RESPIRATORY THERAPY	210,759	0	210,759	0	210,759	65.00
66.00	06600 PHYSICAL THERAPY	744,977	0	744,977	0	744,977	66.00
69.00	06900 ELECTROCARDIOLOGY	624,227		624,227	0	624,227	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	775,455		775,455	0	775,455	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,419,503		1,419,503	0	1,419,503	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,758,038		1,758,038	0	1,758,038	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100 EMERGENCY	0		0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	104,530		104,530		104,530	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	12,107,445	0	12,107,445	39,551	12,146,996	200.00
201.00	Less Observation Beds	104,530		104,530		104,530	201.00
202.00	Total (see instructions)	12,002,915	0	12,002,915	39,551	12,042,466	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150182

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/28/2014 11:34 am

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII		Hospital			PPS		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	285,049		285,049		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,013,254	3,884,548	4,897,802	0.690084	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,570	1,130,414	1,143,984	0.872699	54.00
60.00	06000	LABORATORY	108,073	946,796	1,054,869	0.501264	60.00
64.00	06400	INTRAVENOUS THERAPY	0	266,938	266,938	1.332223	64.00
65.00	06500	RESPIRATORY THERAPY	111,872	109,480	221,352	0.952144	65.00
66.00	06600	PHYSICAL THERAPY	130,877	326,418	457,295	1.629095	66.00
69.00	06900	ELECTROCARDIOLOGY	1,499	5,751	7,250	86.100276	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	521,878	1,546,265	2,068,143	0.374952	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,654,724	688,688	2,343,412	0.605742	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	260,958	8,069,118	8,330,076	0.211047	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	30,245	30,245	3.456108	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	4,101,754	17,004,661	21,106,415		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	4,101,754	17,004,661	21,106,415		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150182	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/28/2014 11:34 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.691896		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.899514		54.00
60.00	06000 LABORATORY	0.501264		60.00
64.00	06400 INTRAVENOUS THERAPY	1.332223		64.00
65.00	06500 RESPIRATORY THERAPY	0.952144		65.00
66.00	06600 PHYSICAL THERAPY	1.629095		66.00
69.00	06900 ELECTROCARDIOLOGY	86.100276		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.374952		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.605742		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.211047		73.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3.456108		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150182

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

Worksheet C  
Part I  
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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
<b>INPATIENT SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS	1,207,318		1,207,318	0	1,207,318 30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	3,379,895		3,379,895	8,875	3,388,770 50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	998,354		998,354	30,676	1,029,030 54.00
60.00	06000 LABORATORY	528,768		528,768	0	528,768 60.00
64.00	06400 INTRAVENOUS THERAPY	355,621		355,621	0	355,621 64.00
65.00	06500 RESPIRATORY THERAPY	210,759	0	210,759	0	210,759 65.00
66.00	06600 PHYSICAL THERAPY	744,977	0	744,977	0	744,977 66.00
69.00	06900 ELECTROCARDIOLOGY	624,227		624,227	0	624,227 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	775,455		775,455	0	775,455 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,419,503		1,419,503	0	1,419,503 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,758,038		1,758,038	0	1,758,038 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00	09100 EMERGENCY	0		0	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	104,530		104,530		104,530 92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					
200.00	Subtotal (see instructions)	12,107,445	0	12,107,445	39,551	12,146,996 200.00
201.00	Less Observation Beds	104,530		104,530		104,530 201.00
202.00	Total (see instructions)	12,002,915	0	12,002,915	39,551	12,042,466 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150182

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/28/2014 11:34 am

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XIX		Hospital			PPS		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	285,049		285,049		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,013,254	3,884,548	4,897,802	0.690084	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,570	1,130,414	1,143,984	0.872699	54.00
60.00	06000	LABORATORY	108,073	946,796	1,054,869	0.501264	60.00
64.00	06400	INTRAVENOUS THERAPY	0	266,938	266,938	1.332223	64.00
65.00	06500	RESPIRATORY THERAPY	111,872	109,480	221,352	0.952144	65.00
66.00	06600	PHYSICAL THERAPY	130,877	326,418	457,295	1.629095	66.00
69.00	06900	ELECTROCARDIOLOGY	1,499	5,751	7,250	86.100276	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	521,878	1,546,265	2,068,143	0.374952	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,654,724	688,688	2,343,412	0.605742	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	260,958	8,069,118	8,330,076	0.211047	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	30,245	30,245	3.456108	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	4,101,754	17,004,661	21,106,415		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	4,101,754	17,004,661	21,106,415		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150182

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

Worksheet C  
Part I  
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Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		11.00			
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.691896			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.899514			54.00
60.00	06000 LABORATORY	0.501264			60.00
64.00	06400 INTRAVENOUS THERAPY	1.332223			64.00
65.00	06500 RESPIRATORY THERAPY	0.952144			65.00
66.00	06600 PHYSICAL THERAPY	1.629095			66.00
69.00	06900 ELECTROCARDIOLOGY	86.100276			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.374952			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.605742			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.211047			73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3.456108			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

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

Provider CCN: 150182

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

Worksheet C Part II Date/Time Prepared: 5/28/2014 11:34 am

Cost Center Description		Title XIX			Hospital	PPS		
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	3,379,895	1,323,041	2,056,854	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	998,354	283,605	714,749	0	0	54.00
60.00	06000	LABORATORY	528,768	73,973	454,795	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	355,621	5,968	349,653	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	210,759	5,463	205,296	0	0	65.00
66.00	06600	PHYSICAL THERAPY	744,977	359,030	385,947	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	624,227	495,656	128,571	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	775,455	62,856	712,599	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,419,503	125,365	1,294,138	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,758,038	158,592	1,599,446	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	104,530	23,718	80,812	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	10,900,127	2,917,267	7,982,860	0	0	200.00
201.00		Less Observation Beds	104,530	23,718	80,812	0	0	201.00
202.00		Total (line 200 minus line 201)	10,795,597	2,893,549	7,902,048	0	0	202.00

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

Provider CCN: 150182

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

Worksheet C Part II Date/Time Prepared: 5/28/2014 11:34 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
		6.00	7.00	8.00	
Title XIX Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	3,379,895	4,897,802	0.690084	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	998,354	1,143,984	0.872699	54.00
60.00	06000 LABORATORY	528,768	1,054,869	0.501264	60.00
64.00	06400 INTRAVENOUS THERAPY	355,621	266,938	1.332223	64.00
65.00	06500 RESPIRATORY THERAPY	210,759	221,352	0.952144	65.00
66.00	06600 PHYSICAL THERAPY	744,977	457,295	1.629095	66.00
69.00	06900 ELECTROCARDIOLOGY	624,227	7,250	86.100276	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	775,455	2,068,143	0.374952	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,419,503	2,343,412	0.605742	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,758,038	8,330,076	0.211047	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0	0	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	104,530	30,245	3.456108	92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (sum of lines 50 thru 199)	10,900,127	20,821,366		200.00
201.00	Less Observation Beds	104,530	0		201.00
202.00	Total (line 200 minus line 201)	10,795,597	20,821,366		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150182

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

Worksheet C  
Part I  
Date/Time Prepared:  
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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	1,207,318		1,207,318	0	1,207,318	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	3,379,895		3,379,895	8,875	3,388,770	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	998,354		998,354	30,676	1,029,030	54.00
60.00	06000 LABORATORY	528,768		528,768	0	528,768	60.00
64.00	06400 INTRAVENOUS THERAPY	355,621		355,621	0	355,621	64.00
65.00	06500 RESPIRATORY THERAPY	210,759	0	210,759	0	210,759	65.00
66.00	06600 PHYSICAL THERAPY	744,977	0	744,977	0	744,977	66.00
69.00	06900 ELECTROCARDIOLOGY	624,227		624,227	0	624,227	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	775,455		775,455	0	775,455	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,419,503		1,419,503	0	1,419,503	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,758,038		1,758,038	0	1,758,038	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0		0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	104,530		104,530		104,530	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	12,107,445	0	12,107,445	39,551	12,146,996	200.00
201.00	Less Observation Beds	104,530		104,530		104,530	201.00
202.00	Total (see instructions)	12,002,915	0	12,002,915	39,551	12,042,466	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150182

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/28/2014 11:34 am

		Title V			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	285,049		285,049		30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	1,013,254	3,884,548	4,897,802	0.690084	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,570	1,130,414	1,143,984	0.872699	54.00
60.00	06000	LABORATORY	108,073	946,796	1,054,869	0.501264	60.00
64.00	06400	INTRAVENOUS THERAPY	0	266,938	266,938	1.332223	64.00
65.00	06500	RESPIRATORY THERAPY	111,872	109,480	221,352	0.952144	65.00
66.00	06600	PHYSICAL THERAPY	130,877	326,418	457,295	1.629095	66.00
69.00	06900	ELECTROCARDIOLOGY	1,499	5,751	7,250	86.100276	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	521,878	1,546,265	2,068,143	0.374952	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,654,724	688,688	2,343,412	0.605742	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	260,958	8,069,118	8,330,076	0.211047	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	30,245	30,245	3.456108	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	4,101,754	17,004,661	21,106,415		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	4,101,754	17,004,661	21,106,415		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150182

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

Worksheet C  
Part I  
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Cost Center Description		PPS Inpatient Ratio	Title V	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
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
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: 150182		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part I Date/Time Prepared: 5/28/2014 11:34 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	273,939	0	273,939	231	1,185.88	
200.00	Total (Lines 30-199)	273,939		273,939	231	200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	52	61,666	30.00			
200.00	Total (Lines 30-199)	52	61,666	200.00			

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150182	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/28/2014 11:34 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,323,041	4,897,802	0.270130	192,854	52,096	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	283,605	1,143,984	0.247910	3,849	954	54.00
60.00	06000 LABORATORY	73,973	1,054,869	0.070125	24,033	1,685	60.00
64.00	06400 INTRAVENOUS THERAPY	5,968	266,938	0.022357	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	5,463	221,352	0.024680	25,289	624	65.00
66.00	06600 PHYSICAL THERAPY	359,030	457,295	0.785117	33,060	25,956	66.00
69.00	06900 ELECTROCARDIOLOGY	495,656	7,250	68.366345	1,499	102,481	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	62,856	2,068,143	0.030392	119,177	3,622	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	125,365	2,343,412	0.053497	344,268	18,417	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	158,592	8,330,076	0.019038	67,250	1,280	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0	0	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	23,718	30,245	0.784196	0	0	92.00
200.00	Total (lines 50-199)	2,917,267	20,821,366		811,279	207,115	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150182		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part III Date/Time Prepared: 5/28/2014 11:34 am	
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
200.00		Total (lines 30-199)	0	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	231	0.00	52	0		30.00
200.00		Total (lines 30-199)	231		52	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150182

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

Worksheet D  
Part IV  
Date/Time Prepared:  
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Cost Center Description		Title XVIII			Hospital		PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
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: 150182	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/28/2014 11:34 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	PPS
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	4,897,802	0.000000	0.000000	192,854	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	1,143,984	0.000000	0.000000	3,849	54.00
60.00	06000 LABORATORY	0	1,054,869	0.000000	0.000000	24,033	60.00
64.00	06400 INTRAVENOUS THERAPY	0	266,938	0.000000	0.000000	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	221,352	0.000000	0.000000	25,289	65.00
66.00	06600 PHYSICAL THERAPY	0	457,295	0.000000	0.000000	33,060	66.00
69.00	06900 ELECTROCARDIOLOGY	0	7,250	0.000000	0.000000	1,499	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,068,143	0.000000	0.000000	119,177	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	2,343,412	0.000000	0.000000	344,268	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	8,330,076	0.000000	0.000000	67,250	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100 EMERGENCY	0	0	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	30,245	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	20,821,366			811,279	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150182

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

Worksheet D  
Part IV  
Date/Time Prepared:  
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XVIII Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	410,395	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	102,330	0	54.00
60.00	06000 LABORATORY	0	67,849	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	40,135	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	14,747	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	922	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	150,629	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	149,211	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,624,026	0	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,190	0	92.00
200.00	Total (lines 50-199)	0	2,561,434	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150182	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/28/2014 11:34 am				
		Title XVIII	Hospital	PPS				
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.690084	410,395	0	0	283,207	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.872699	102,330	0	0	89,303	54.00
60.00	06000	LABORATORY	0.501264	67,849	0	0	34,010	60.00
64.00	06400	INTRAVENOUS THERAPY	1.332223	40,135	0	0	53,469	64.00
65.00	06500	RESPIRATORY THERAPY	0.952144	14,747	0	0	14,041	65.00
66.00	06600	PHYSICAL THERAPY	1.629095	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	86.100276	922	0	0	79,384	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.374952	150,629	0	0	56,479	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.605742	149,211	0	0	90,383	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211047	1,624,026	289	0	342,746	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3.456108	1,190	0	0	4,113	92.00
200.00		Subtotal (see instructions)		2,561,434	289	0	1,047,135	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		2,561,434	289	0	1,047,135	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150182	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/28/2014 11:34 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000 LABORATORY	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	61	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
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)	61	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	61	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150182		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part I Date/Time Prepared: 5/28/2014 11:34 am	
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)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	273,939	0	273,939	231	1,185.88	30.00
200.00	Total (Lines 30-199)	273,939		273,939	231		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	3	3,558				
200.00	Total (Lines 30-199)	3	3,558				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150182	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/28/2014 11:34 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	1,323,041	4,897,802	0.270130	14,706	3,973	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	283,605	1,143,984	0.247910	4,452	1,104	54.00
60.00	06000 LABORATORY	73,973	1,054,869	0.070125	345	24	60.00
64.00	06400 INTRAVENOUS THERAPY	5,968	266,938	0.022357	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	5,463	221,352	0.024680	2,596	64	65.00
66.00	06600 PHYSICAL THERAPY	359,030	457,295	0.785117	600	471	66.00
69.00	06900 ELECTROCARDIOLOGY	495,656	7,250	68.366345	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	62,856	2,068,143	0.030392	6,172	188	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	125,365	2,343,412	0.053497	10,732	574	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	158,592	8,330,076	0.019038	2,665	51	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100 EMERGENCY	0	0	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	23,718	30,245	0.784196	0	0	92.00
200.00	Total (lines 50-199)	2,917,267	20,821,366		42,268	6,449	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150182		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part III Date/Time Prepared: 5/28/2014 11:34 am			
Cost Center Description			Title XIX			Hospital		PPS		
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)			
			1.00	2.00	3.00	4.00	5.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0			30.00
200.00		Total (lines 30-199)	0	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	231	0.00		3	0		30.00	
200.00		Total (lines 30-199)	231			3	0		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150182

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/28/2014 11:34 am

Cost Center Description		Title XIX			Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
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: 150182

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

Worksheet D  
Part IV  
Date/Time Prepared:  
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Cost Center Description			Title XIX			Hospital		PPS
			Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	4,897,802	0.000000	0.000000	14,706	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,143,984	0.000000	0.000000	4,452	54.00
60.00	06000	LABORATORY	0	1,054,869	0.000000	0.000000	345	60.00
64.00	06400	INTRAVENOUS THERAPY	0	266,938	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	221,352	0.000000	0.000000	2,596	65.00
66.00	06600	PHYSICAL THERAPY	0	457,295	0.000000	0.000000	600	66.00
69.00	06900	ELECTROCARDIOLOGY	0	7,250	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,068,143	0.000000	0.000000	6,172	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,343,412	0.000000	0.000000	10,732	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,330,076	0.000000	0.000000	2,665	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	30,245	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	20,821,366			42,268	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150182	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/28/2014 11:34 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
Title XIX Hospital PPS						
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150182	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/28/2014 11:34 am
	Title XIX	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0.690084	0	131,981	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.872699	0	47,762	0	0
60.00 06000 LABORATORY	0.501264	0	37,681	0	0
64.00 06400 INTRAVENOUS THERAPY	1.332223	0	26,657	0	0
65.00 06500 RESPIRATORY THERAPY	0.952144	0	4,834	0	0
66.00 06600 PHYSICAL THERAPY	1.629095	0	2,727	0	0
69.00 06900 ELECTROCARDIOLOGY	86.100276	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.374952	0	61,163	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.605742	0	17,225	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.211047	0	148,151	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00 09100 EMERGENCY	0.000000	0	0	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3.456108	0	2,561	0	0
200.00 Subtotal (see instructions)		0	480,742	0	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00 Net Charges (line 200 +/- line 201)		0	480,742	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150182	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/28/2014 11:34 am
		Title XIX	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	91,078	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	41,682	0	54.00
60.00	06000 LABORATORY	18,888	0	60.00
64.00	06400 INTRAVENOUS THERAPY	35,513	0	64.00
65.00	06500 RESPIRATORY THERAPY	4,603	0	65.00
66.00	06600 PHYSICAL THERAPY	4,443	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	22,933	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	10,434	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	31,267	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	8,851	0	92.00
200.00	Subtotal (see instructions)	269,692	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	269,692	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150182	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/28/2014 11:34 am
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		231	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		231	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)		211	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)		52	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
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,207,318	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,207,318	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,207,318	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		5,226.48	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		271,777	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)		271,777	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150182		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
Date/Time Prepared: 5/28/2014 11:34 am		Title XVIII		Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)							42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT							43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					623,362		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					895,139		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)					61,666		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					207,115		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					268,781		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					626,358		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)					20		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					5,226.48		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					104,530		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150182		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/28/2014 11:34 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	273,939	1,207,318	0.226899	104,530	23,718	90.00
91.00	Nursing School cost	0	1,207,318	0.000000	104,530	0	91.00
92.00	Allied health cost	0	1,207,318	0.000000	104,530	0	92.00
93.00	All other Medical Education	0	1,207,318	0.000000	104,530	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150182	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/28/2014 11:34 am
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		231	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		231	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)		211	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		3	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
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,207,318	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,207,318	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,207,318	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		5,226.48	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		15,679	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)		15,679	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150182		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
Date/Time Prepared: 5/28/2014 11:34 am		Title XIX		Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)							42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT							43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					27,179		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					42,858		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)					3,558		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					6,449		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					10,007		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					32,851		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)					20		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					5,226.48		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					104,530		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150182		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/28/2014 11:34 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	273,939	1,207,318	0.226899	104,530	23,718	90.00
91.00	Nursing School cost	0	1,207,318	0.000000	104,530	0	91.00
92.00	Allied health cost	0	1,207,318	0.000000	104,530	0	92.00
93.00	All other Medical Education	0	1,207,318	0.000000	104,530	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150182	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/28/2014 11:34 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		70,275		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.691896	192,854	133,435	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.899514	3,849	3,462	54.00
60.00	06000 LABORATORY	0.501264	24,033	12,047	60.00
64.00	06400 INTRAVENOUS THERAPY	1.332223	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.952144	25,289	24,079	65.00
66.00	06600 PHYSICAL THERAPY	1.629095	33,060	53,858	66.00
69.00	06900 ELECTROCARDIOLOGY	86.100276	1,499	129,064	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.374952	119,177	44,686	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.605742	344,268	208,538	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.211047	67,250	14,193	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3.456108	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		811,279	623,362	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		811,279		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150182	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/28/2014 11:34 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		4,054		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.691896	14,706	10,175	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.899514	4,452	4,005	54.00
60.00	06000 LABORATORY	0.501264	345	173	60.00
64.00	06400 INTRAVENOUS THERAPY	1.332223	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.952144	2,596	2,472	65.00
66.00	06600 PHYSICAL THERAPY	1.629095	600	977	66.00
69.00	06900 ELECTROCARDIOLOGY	86.100276	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.374952	6,172	2,314	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.605742	10,732	6,501	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.211047	2,665	562	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3.456108	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		42,268	27,179	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)		42,268		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150182	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/28/2014 11:34 am
		Title XVIII	Hospital	PPS
		0	1.00	2.00
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER PPS</b>				
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)		95,164	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		156,398	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI (see instructions)		0	1.03
2.00	Outlier payments for discharges. (see instructions)		0	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		5.95	4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
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
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		0.00	30.00
31.00	Percentage of Medicaid patient days (see instructions)		0.00	31.00
32.00	Sum of lines 30 and 31		0.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00	33.00
34.00	Disproportionate share adjustment (see instructions)		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150182	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/28/2014 11:34 am	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1	On/After October 1	
			1.00	2.00	
<b>Uncompensated Care Adjustment</b>					
35.00	Total uncompensated care amount (see instructions)			9,046,380,143	35.00
35.01	Factor 3 (see instructions)			0.00000027	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)			0	36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)			0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)			0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)			0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41)			0	46.00
47.00	Subtotal (see instructions)		251,562		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)			0	48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		251,562		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		228,464		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)		480,026		59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		480,026		61.00
62.00	Deductibles billed to program beneficiaries			24,864	62.00
63.00	Coinurance billed to program beneficiaries			0	63.00
64.00	Allowable bad debts (see instructions)			0	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			0	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		455,162		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)			0	70.93
70.94	Hospital readmissions reduction adjustment (see instructions)			0	70.94
70.95	Recovery of Accelerated Depreciation			0	70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150182	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/28/2014 11:34 am	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	On/After October 1 2.00	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		455,162		71.00
71.01	Sequestration adjustment (see instructions)		6,873		71.01
72.00	Interim payments		241,821		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		206,468		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0		75.00
<b>TO BE COMPLETED BY CONTRACTOR</b>					
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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150182	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/28/2014 11:34 am
		Title XVII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		61	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,047,135	2.00
3.00	PPS payments		493,506	3.00
4.00	Outlier payment (see instructions)		1,041	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		61	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		289	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)		289	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		289	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		228	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)		61	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)		494,547	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
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)		78,439	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)		416,169	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)		416,169	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		416,169	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		6,361	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		4,135	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		61	36.00
37.00	Subtotal (see instructions)		420,304	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		420,304	40.00
40.01	Sequestration adjustment (see instructions)		6,347	40.01
41.00	Interim payments		407,922	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		6,035	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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: 150182

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/28/2014 11:34 am

Title XVIII

Hospital

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		241,821		407,922	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		241,821		407,922	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		206,468		6,035	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		448,289		413,957	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: 150182

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

Worksheet E-1  
Part II  
Date/Time Prepared:  
5/28/2014 11:34 am

		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			104 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			52 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			0 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			211 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			21,106,415 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			252,943 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)			500,000 8.00
9.00	Sequestration adjustment amount (see instructions)			10,000 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			490,000 10.00
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			490,000 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150182	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part VII Date/Time Prepared: 5/28/2014 11:34 am	
		Title XIX	Hospital	PPS	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			269,692	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	269,692	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	269,692	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		42,268	480,742	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		42,268	480,742	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		42,268	480,742	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		42,268	211,050	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	269,692	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0	0	24.00
25.00	Capital exception payments (see instructions)		0	0	25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	269,692	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	269,692	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	269,692	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	269,692	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	269,692	40.00
41.00	Interim payments		0	269,692	41.00
42.00	Balance due provider/program (line 40 minus 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0	43.00

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

Provider CCN: 150182

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

Worksheet G

Date/Time Prepared:  
5/28/2014 11:34 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	719,941	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,426,855	0	0	0	4.00
5.00	Other receivable	119,005	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,887,438	0	0	0	6.00
7.00	Inventory	485,653	0	0	0	7.00
8.00	Prepaid expenses	60,599	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	2,924,615	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	8,985,905	0	0	0	13.00
14.00	Accumulated depreciation	-1,793,946	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	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	8,742,043	0	0	0	23.00
24.00	Accumulated depreciation	-1,745,261	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)	14,188,741	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	17,113,356	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	665,924	0	0	0	37.00
38.00	Salaries, wages, and fees payable	253,863	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	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	-4,848	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	914,939	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	2,819,520	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	-94,360	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,725,160	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,640,099	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	13,473,257				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)	13,473,257	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	17,113,356	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150182

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

Worksheet G-1

Date/Time Prepared:  
5/28/2014 11:34 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		8,924,099		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-6,114,932			2.00
3.00	Total (sum of line 1 and line 2)		2,809,167		0	3.00
4.00	FUND CHANGES	10,664,076		0		4.00
5.00	ROUNDING	14		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		10,664,090		0	10.00
11.00	Subtotal (line 3 plus line 10)		13,473,257		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		13,473,257		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	FUND CHANGES		0			4.00
5.00	ROUNDING		0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150182

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/28/2014 11:34 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	316,331		316,331	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)	316,331		316,331	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	316,331		316,331	17.00
18.00	Ancillary services	3,815,894	16,974,190	20,790,084	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,132,225	16,974,190	21,106,415	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		12,596,179		29.00
30.00	SHARED SERVICES EXPENSE	2,368,449			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)		2,368,449		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		14,964,628		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150182

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

Worksheet G-3

Date/Time Prepared:  
5/28/2014 11:34 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	21,106,415	1.00
2.00	Less contractual allowances and discounts on patients' accounts	13,880,830	2.00
3.00	Net patient revenues (line 1 minus line 2)	7,225,585	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	14,964,628	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-7,739,043	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	3,146	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	21,536	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	430,928	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER	1,168,501	24.00
25.00	Total other income (sum of lines 6-24)	1,624,111	25.00
26.00	Total (line 5 plus line 25)	-6,114,932	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-6,114,932	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150182	Period: From 01/01/2013 To 12/31/2013	Worksheet L Parts I-III Date/Time Prepared: 5/28/2014 11:34 am
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		0	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		0.00	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)		0	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		61,666	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		207,115	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		268,781	3.00
4.00	Capital cost payment factor (see instructions)		85	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		228,464	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
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