

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: 150165	Period: From 07/01/2013 To 12/31/2013	Worksheet S Parts I-III Date/Time Prepared: 6/3/2014 9:47 am
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<b>PART I - COST REPORT STATUS</b>			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 6/3/2014	Time: 9:47 am
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCSAN HEALTH MUNSTER ( 150165 ) for the cost reporting period beginning 07/01/2013 and ending 12/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) \_\_\_\_\_  
 Officer or Administrator of Provider(s)

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	15,464	24,473	498,526	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00 Total	0	15,464	24,473	498,526	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: 150165		Period: From 07/01/2013 To 12/31/2013		Worksheet S-2 Part I Date/Time Prepared: 6/3/2014 9:46 am				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 701 SUPERIOR STREET			PO Box:				1.00				
2.00	City: MUNSTER			State: IN		Zip Code: 46321		County: LAKE				
		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			FRANCSAN HEALTH MUNSTER	150165	23844	1	06/01/2007	N	P	P	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
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)						07/01/2013		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				22.01	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						2		N		23.00	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid 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.			23	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				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	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
<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.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.					58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 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		
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
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	
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)			N	63.00	
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
<b>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.</b>						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	3.00	
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 Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
<b>Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010</b>						
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
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)					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)					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		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	97.00
<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)						106.00

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		V	XIX			
		1.00	2.00			
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00	
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	32,641	0			118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y				140.00

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1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: FRANCSAN ALLIANCE,	Contractor's Name: WISCONSIN PHYSICIAN SERVICE		Contractor's Number: 8001			
142.00	Street: 1515 DRAGOON TRAIL	PO Box:					
143.00	City: MISHAWAKA	State: IN		Zip Code: 46546			
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?				Y		
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.				Y		
				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		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N		
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N		
156.00	Subprovider - IPF	N	N	N	N		
157.00	Subprovider - IRF	N	N	N	N		
158.00	SUBPROVIDER						
159.00	SNF	N	N	N	N		
160.00	HOME HEALTH AGENCY	N	N	N	N		
161.00	CMHC		N	N	N		
				1.00			
165.00	Multi campus 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		
		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		
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)				0.50		
				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)			01/01/2013	06/30/2013		

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150165		Period: From 07/01/2013 To 12/31/2013		Worksheet S-2 Part II Date/Time Prepared: 6/3/2014 9:46 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)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			N			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)			N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			Y	11/22/2013	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150165	Period: From 07/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 6/3/2014 9:46 am
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	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.			N	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.			Y	12/31/2013
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.	NANCY		RI LEY	
42.00	Enter the employer/company name of the cost report preparer.	FRANCSAN ST. MARGARET HEALTH			
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	219-932-2300 X33175		NANCY.RI LEY@FRANCSANALLIAN CE.ORG	

		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)		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)	11/22/2013	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
<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.	REGIONAL REIMBURSEMENT MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet S-3  
Part I  
Date/Time Prepared:  
6/3/2014 9:46 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	23	4,232	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)		23	4,232	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	9	1,656	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		32	5,888	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	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		32				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: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet S-3  
Part I  
Date/Time Prepared:  
6/3/2014 9:46 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)	884	23	1,250			1.00
2.00 HMO and other (see instructions)	10	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)	884	23	1,250			7.00
8.00 INTENSIVE CARE UNIT	68	8	641			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)	952	31	1,891	0.00	162.94	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	0	0	0	0.00	0.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	162.94	27.00
28.00 Observation Bed Days		0	715			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: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet S-3  
Part I  
Date/Time Prepared:  
6/3/2014 9:46 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	207	7	464	1.00
2.00 HMO and other (see instructions)			1			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	207	7	464	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	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					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: 150165	Period: From 07/01/2013 To 12/31/2013	Worksheet S-3 Part II Date/Time Prepared: 6/3/2014 9:46 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	10,123,745	0	10,123,745	338,917.00	29.87
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)		336,942	0	336,942	2,706.00	124.52
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract labor (see instructions)		0	0	0	0.00	0.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative	266,122	5,392	271,514	5,392.00	50.35	13.00
14.00	Home office salaries & wage-related costs	2,214,575	0	2,214,575	42,875.00	51.65	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		2,203,440	0	2,203,440		17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0		18.00
19.00	Excluded areas	38,517	0	38,517			19.00
20.00	Non-physician anesthetist Part A		0	0	0		20.00
21.00	Non-physician anesthetist Part B		0	0	0		21.00
22.00	Physician Part A - Administrative		0	0	0		22.00
22.01	Physician Part A - Teaching		0	0	0		22.01
23.00	Physician Part B		0	0	0		23.00
24.00	Wage-related costs (RHC/FOHC)		0	0	0		24.00
25.00	Interns & residents (in an approved program)		0	0	0		25.00
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits Department	4.00	89,799	0	89,799	3,093.00	29.03
27.00	Administrative & General	5.00	1,624,361	0	1,624,361	88,794.00	18.29
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00
29.00	Maintenance & Repairs	6.00	180,966	0	180,966	5,826.00	31.06
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00
31.00	Laundry & Linen Service	8.00	25,531	0	25,531	2,023.00	12.62
32.00	Housekeeping	9.00	149,036	0	149,036	12,595.00	11.83
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	22,167	0	22,167	795.00	27.88
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	404,217	0	404,217	8,893.00	45.45
39.00	Central Services and Supply	14.00	47,008	0	47,008	2,646.00	17.77
40.00	Pharmacy	15.00	356,727	0	356,727	6,134.00	58.16
41.00	Medical Records & Medical Records Library	16.00	298,596	0	298,596	14,098.00	21.18

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet S-3  
Part II  
Date/Time Prepared:  
6/3/2014 9:46 am

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

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet S-3  
Part III  
Date/Time Prepared:  
6/3/2014 9:46 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)	10,123,745	0	10,123,745	338,917.00	29.87	1.00
2.00	Excluded area salaries (see instructions)	336,942	0	336,942	2,706.00	124.52	2.00
3.00	Subtotal salaries (line 1 minus line 2)	9,786,803	0	9,786,803	336,211.00	29.11	3.00
4.00	Subtotal other wages & related costs (see inst.)	2,480,697	5,392	2,486,089	48,267.00	51.51	4.00
5.00	Subtotal wage-related costs (see inst.)	2,203,440	0	2,203,440	0.00	22.51	5.00
6.00	Total (sum of lines 3 thru 5)	14,470,940	5,392	14,476,332	384,478.00	37.65	6.00
7.00	Total overhead cost (see instructions)	3,198,408	0	3,198,408	144,897.00	22.07	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150165	Period: From 07/01/2013 To 12/31/2013	Worksheet S-3 Part IV Date/Time Prepared: 6/3/2014 9:46 am
			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		152,838	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
<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)		1,363,980	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		2,110	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)		14,171	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		39,448	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		662,093	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		-4,036	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		11,353	23.00
24.00	<b>Total Wage Related cost (Sum of lines 1 -23)</b>		<b>2,241,957</b>	<b>24.00</b>
<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: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet S-3  
Part V  
Date/Time Prepared:  
6/3/2014 9:46 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	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150165	Period: From 07/01/2013 To 12/31/2013	Worksheet S-10 Date/Time Prepared: 6/3/2014 9:46 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)		0.261227	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		664,322	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		Y	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		4,250,462	6.00	
7.00	Medicaid cost (line 1 times line 6)		1,110,335	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)		446,013	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)		446,013	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	5,500	11,900	17,400	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,437	3,109	4,546	21.00
22.00	Partial payment by patients approved for charity care	200	1,200	1,400	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,237	1,909	3,146	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?				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)			2,200,163	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			41,321	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			2,158,842	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			563,948	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			567,094	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			1,013,107	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet A  
Date/Time Prepared:  
6/3/2014 9:46 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (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		1,740,525	1,740,525	1,012,462	2,752,987	1.00
2.00	00200		0	0	0	0	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	89,799	2,245,842	2,335,641	30,750	2,366,391	4.00
5.00	00500	1,624,361	7,612,130	9,236,491	-999,385	8,237,106	5.00
6.00	00600	180,966	543,480	724,446	0	724,446	6.00
7.00	00700	0	0	0	0	0	7.00
8.00	00800	25,531	-6,417	19,114	0	19,114	8.00
9.00	00900	149,036	50,532	199,568	0	199,568	9.00
10.00	01000	22,167	78,671	100,838	0	100,838	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	404,217	5,893	410,110	0	410,110	13.00
14.00	01400	47,008	28,319	75,327	0	75,327	14.00
15.00	01500	356,727	3,788,503	4,145,230	-3,667,953	477,277	15.00
16.00	01600	298,596	78,997	377,593	0	377,593	16.00
17.00	01700	0	0	0	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	1,024,028	57,471	1,081,499	-9,086	1,072,413	30.00
31.00	03100	527,334	62,305	589,639	-22,133	567,506	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	1,355,018	3,433,785	4,788,803	-1,828,402	2,960,401	50.00
51.00	05100	841,071	68,209	909,280	-25,595	883,685	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	53,773	53,773	-17,700	36,073	53.00
54.00	05400	1,044,375	678,947	1,723,322	-139,753	1,583,569	54.00
55.00	05500	0	0	0	0	0	55.00
57.00	05700	131,657	152,153	283,810	-1,497	282,313	57.00
58.00	05800	143,416	247,293	390,709	-133	390,576	58.00
59.00	05900	310,525	686,570	997,095	-395,571	601,524	59.00
60.00	06000	8,134	2,194,339	2,202,473	0	2,202,473	60.00
64.00	06400	0	0	0	0	0	64.00
64.01	06401	1,252	396	1,648	0	1,648	64.01
65.00	06500	253,123	9,032	262,155	-4,691	257,464	65.00
66.00	06600	124,796	3,292	128,088	-582	127,506	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	215,008	14,931	229,939	-34	229,905	69.00
70.00	07000	324,552	879,810	1,204,362	-183	1,204,179	70.00
71.00	07100	0	0	0	1,435,245	1,435,245	71.00
72.00	07200	0	0	0	825,116	825,116	72.00
73.00	07300	0	0	0	2,287,108	2,287,108	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
90.01	09001	139,489	-1,491,191	-1,351,702	1,507,384	155,682	90.01
90.02	09002	144,617	228,530	373,147	-7,286	365,861	90.02
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	-21,919	-21,919	21,919	0	113.00
118.00		9,786,803	23,424,201	33,211,004	0	33,211,004	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	336,942	18,450	355,392	0	355,392	192.00
193.00	19300	0	0	0	0	0	193.00
200.00		10,123,745	23,442,651	33,566,396	0	33,566,396	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet A  
Date/Time Prepared:  
6/3/2014 9:46 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	-439,554	2,313,433	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,500	2,375,891	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	275,165	8,512,271	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	724,446	6.00
7.00	00700	OPERATION OF PLANT	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	19,114	8.00
9.00	00900	HOUSEKEEPING	0	199,568	9.00
10.00	01000	DIETARY	0	100,838	10.00
11.00	01100	CAFETERIA	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	410,110	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	75,327	14.00
15.00	01500	PHARMACY	0	477,277	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	377,593	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	0	1,072,413	30.00
31.00	03100	INTENSIVE CARE UNIT	0	567,506	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-6,381	2,954,020	50.00
51.00	05100	RECOVERY ROOM	0	883,685	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	36,073	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,583,569	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00	05700	CT SCAN	0	282,313	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	390,576	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	601,524	59.00
60.00	06000	LABORATORY	0	2,202,473	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	1,648	64.01
65.00	06500	RESPIRATORY THERAPY	0	257,464	65.00
66.00	06600	PHYSICAL THERAPY	0	127,506	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	229,905	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,204,179	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,435,245	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	825,116	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,287,108	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	CLINIC	0	155,682	90.01
90.02	09002	CLINIC	0	365,861	90.02
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	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)	-161,270	33,049,734	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	355,392	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		TOTAL (SUM OF LINES 118-199)	-161,270	33,405,126	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - INSURANCE</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	124,828	1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	30,750	2.00
	TOTALS		0	155,578	
<b>B - INTEREST EXPENSE</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	909,553	1.00
	TOTALS		0	909,553	
<b>C - DRUG EXPENSE</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,287,108	1.00
2.00	CLINIC	90.01	0	1,513,182	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
	TOTALS		0	3,800,290	
<b>D - MEDICAL SUPPLIES EXPENSE</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,435,245	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	65,804	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
	TOTALS		0	1,501,049	
<b>E - IMPLANTABLE DEVICES</b>					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	825,116	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	825,116	
<b>F - INTEREST</b>					
1.00	INTEREST EXPENSE	113.00	0	21,919	1.00
	TOTALS		0	21,919	
500.00	Grand Total: Increases		0	7,213,505	500.00

RECLASSIFICATIONS

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet A-6  
Date/Time Prepared:  
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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - INSURANCE</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	155,578	9	1.00	
2.00		0.00	0	0	0	2.00	
	TOTALS		0	155,578			
<b>B - INTEREST EXPENSE</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	909,553	9	1.00	
	TOTALS		0	909,553			
<b>C - DRUG EXPENSE</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	58	0	1.00	
2.00	PHARMACY	15.00	0	3,667,953	0	2.00	
3.00	ADULTS & PEDIATRICS	30.00	0	4	0	3.00	
4.00	INTENSIVE CARE UNIT	31.00	0	4	0	4.00	
5.00	OPERATING ROOM	50.00	0	472	0	5.00	
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	130,717	0	6.00	
7.00	CT SCAN	57.00	0	124	0	7.00	
8.00	CLINIC	90.02	0	958	0	8.00	
	TOTALS		0	3,800,290			
<b>D - MEDICAL SUPPLIES EXPENSE</b>							
1.00	ADULTS & PEDIATRICS	30.00	0	9,082	0	1.00	
2.00	INTENSIVE CARE UNIT	31.00	0	22,129	0	2.00	
3.00	OPERATING ROOM	50.00	0	1,296,749	0	3.00	
4.00	RECOVERY ROOM	51.00	0	25,595	0	4.00	
5.00	ANESTHESIOLOGY	53.00	0	17,700	0	5.00	
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	9,036	0	6.00	
7.00	CT SCAN	57.00	0	1,373	0	7.00	
8.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	133	0	8.00	
9.00	CARDIAC CATHETERIZATION	59.00	0	101,636	0	9.00	
10.00	RESPIRATORY THERAPY	65.00	0	4,691	0	10.00	
11.00	PHYSICAL THERAPY	66.00	0	582	0	11.00	
12.00	ELECTROCARDIOLOGY	69.00	0	34	0	12.00	
13.00	ELECTROENCEPHALOGRAPHY	70.00	0	183	0	13.00	
14.00	CLINIC	90.01	0	5,798	0	14.00	
15.00	CLINIC	90.02	0	6,328	0	15.00	
	TOTALS		0	1,501,049			
<b>E - IMPLANTABLE DEVICES</b>							
1.00	OPERATING ROOM	50.00	0	531,181	0	1.00	
2.00	CARDIAC CATHETERIZATION	59.00	0	293,935	0	2.00	
	TOTALS		0	825,116			
<b>F - INTEREST</b>							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	21,919	11	1.00	
	TOTALS		0	21,919			
500.00	Grand Total: Decreases		0	7,213,505		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet A-7  
Part I  
Date/Time Prepared:  
6/3/2014 9:46 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	6,019,200	0	0	0	4,168,411	1.00
2.00	Land Improvements	2,158,788	0	0	0	1,185,229	2.00
3.00	Buildings and Fixtures	0	26,791,055	0	26,791,055	0	3.00
4.00	Building Improvements	4,800,895	0	0	0	4,800,895	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	19,055,788	0	0	0	18,399,205	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,034,671	26,791,055	0	26,791,055	28,553,740	8.00
9.00	Reconciling Items	0	0	0	0	-98,800	9.00
10.00	Total (line 8 minus line 9)	32,034,671	26,791,055	0	26,791,055	28,652,540	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	1,850,789	0				1.00
2.00	Land Improvements	973,559	0				2.00
3.00	Buildings and Fixtures	26,791,055	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	656,583	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	30,271,986	0				8.00
9.00	Reconciling Items	98,800	0				9.00
10.00	Total (line 8 minus line 9)	30,173,186	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet A-7  
Part II  
Date/Time Prepared:  
6/3/2014 9:46 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	1,740,525	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,740,525	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	1,740,525				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1,740,525				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet A-7  
Part III  
Date/Time Prepared:  
6/3/2014 9:46 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	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,335,352	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,335,352	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	-21,919	0	0	0	2,313,433	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	-21,919	0	0	0	2,313,433	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet A-8

Date/Time Prepared:  
6/3/2014 9:46 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)				0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)				0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)	B	-16,943		CAP REL COSTS-BLDG & FIXT	1.00	9	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)	B	-121,549		ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00	0	7.00
8.00 Television and radio service (chapter 21)		0			0.00	0	8.00
9.00 Parking lot (chapter 21)		0			0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-10,109				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	1,134,314				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	B	-145		ADMINISTRATIVE & GENERAL	5.00	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			0RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3			0PHYSICAL 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				0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP				0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist				0NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant				0	0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3			0OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)				0ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3			0SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00
33.00 DONATIONS EXPENSE (51012XXX)	A	-2,735		ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01 PROPERTY TAXES (51009800)	A	-472,409		ADMINISTRATIVE & GENERAL	5.00	0	33.01

Provider CCN: 150165

Period:  
 From 07/01/2013  
 To 12/31/2013

Worksheet A-8

Date/Time Prepared:  
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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		
33.02 OTHER MI SC EXPENSE	A	-332	ADMI NI STRATI VE & GENERAL	5.00	0	33.02
33.03 SPECIAL EVENTS (51016800)	A	-4,619	ADMI NI STRATI VE & GENERAL	5.00	0	33.03
33.04 ADVERTISING (41860XXX)	A	-259,094	ADMI NI STRATI VE & GENERAL	5.00	0	33.04
33.05 RENTAL INCOME	B	-227,114	ADMI NI STRATI VE & GENERAL	5.00	0	33.05
33.06 MISCELLANEOUS - OTHER OPERATING	B	-1,019	ADMI NI STRATI VE & GENERAL	5.00	0	33.06
33.07 DONATIONS/CONTRIBUTIONS	B	-3,522	ADMI NI STRATI VE & GENERAL	5.00	0	33.07
33.08 MISCELLANEOUS REVENUE	B	-5,494	ADMI NI STRATI VE & GENERAL	5.00	0	33.08
33.09 HAF ASSESSMENT FEES	A	-180,000	ADMI NI STRATI VE & GENERAL	5.00	0	33.09
33.10 PENSION	A	9,500	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-161,270				50.00

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

Provider CCN: 150165

Period: From 07/01/2013 To 12/31/2013

Worksheet A-8-1

Date/Time Prepared: 6/3/2014 9:46 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		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>						
1.00	1.00	CAP REL COSTS-BLDG & FIXT	FA-INT	3,607	931,472	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	FA-NEW CAP	505,254	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	FA-A&G	3,434,309	1,855,707	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	FA-COEP	0	21,677	4.00
4.01	0.00			0	0	4.01
4.02	0.00			0	0	4.02
4.03	0.00			0	0	4.03
4.04	0.00			0	0	4.04
4.05	0.00			0	0	4.05
5.00	0		0	3,943,170	2,808,856	5.00

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

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

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

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

6.00	B	FRANCISCAN ALLI	100.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet A-8-1

Date/Time Prepared:  
6/3/2014 9:46 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	-927,865	9		1.00
2.00	505,254	9		2.00
3.00	1,578,602	0		3.00
4.00	-21,677	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
5.00	1,134,314			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>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>		

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

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

6.00		6.00
7.00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet A-8-2

Date/Time Prepared:  
6/3/2014 9:46 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	5.00 ADMINISTRATIVE & GENERAL	2,100	0	2,100	200,300	12
2.00	5.00 ADMINISTRATIVE & GENERAL	233,447	0	233,447	200,300	5,160
3.00	5.00 ADMINISTRATIVE & GENERAL	12,125	0	12,125	200,300	97
4.00	50.00 OPERATING ROOM	18,450	0	18,450	204,100	123
5.00	0.00	0	0	0	0	0
6.00	0.00	0	0	0	0	0
7.00	0.00	0	0	0	0	0
8.00	0.00	0	0	0	0	0
9.00	0.00	0	0	0	0	0
10.00	0.00	0	0	0	0	0
200.00		266,122	0	266,122		5,392

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	5.00 ADMINISTRATIVE & GENERAL	1,156	58	0	0	0
2.00	5.00 ADMINISTRATIVE & GENERAL	496,898	24,845	0	0	0
3.00	5.00 ADMINISTRATIVE & GENERAL	9,341	467	0	0	0
4.00	50.00 OPERATING ROOM	12,069	603	0	0	0
5.00	0.00	0	0	0	0	0
6.00	0.00	0	0	0	0	0
7.00	0.00	0	0	0	0	0
8.00	0.00	0	0	0	0	0
9.00	0.00	0	0	0	0	0
10.00	0.00	0	0	0	0	0
200.00		519,464	25,973	0	0	0

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	5.00 ADMINISTRATIVE & GENERAL	0	1,156	944	944
2.00	5.00 ADMINISTRATIVE & GENERAL	0	496,898	0	0
3.00	5.00 ADMINISTRATIVE & GENERAL	0	9,341	2,784	2,784
4.00	50.00 OPERATING ROOM	0	12,069	6,381	6,381
5.00	0.00	0	0	0	0
6.00	0.00	0	0	0	0
7.00	0.00	0	0	0	0
8.00	0.00	0	0	0	0
9.00	0.00	0	0	0	0
10.00	0.00	0	0	0	0
200.00		0	519,464	10,109	10,109

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet B  
Part I  
Date/Time Prepared:  
6/3/2014 9:46 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,313,433	2,313,433			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	0		0		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,375,891	0	0	2,375,891	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	8,512,271	368,707	0	384,627	9,265,605
6.00 00600	MAINTENANCE & REPAIRS	724,446	0	0	42,850	767,296
7.00 00700	OPERATION OF PLANT	0	67,560	0	0	67,560
8.00 00800	LAUNDRY & LINEN SERVICE	19,114	0	0	6,045	25,159
9.00 00900	HOUSEKEEPING	199,568	4,802	0	35,289	239,659
10.00 01000	DIETARY	100,838	41,524	0	5,249	147,611
11.00 01100	CAFETERIA	0	0	0	0	0
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	410,110	0	0	95,713	505,823
14.00 01400	CENTRAL SERVICES & SUPPLY	75,327	41,908	0	11,131	128,366
15.00 01500	PHARMACY	477,277	6,112	0	84,468	567,857
16.00 01600	MEDICAL RECORDS & LIBRARY	377,593	0	0	70,703	448,296
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00 02000	NURSING SCHOOL	0	0	0	0	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	1,072,413	450,918	0	242,474	1,765,805
31.00 03100	INTENSIVE CARE UNIT	567,506	110,621	0	124,865	802,992
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	2,954,020	450,359	0	320,848	3,725,227
51.00 05100	RECOVERY ROOM	883,685	0	0	199,153	1,082,838
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00 05300	ANESTHESIOLOGY	36,073	0	0	0	36,073
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,583,569	336,315	0	247,292	2,167,176
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
57.00 05700	CT SCAN	282,313	0	0	31,174	313,487
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	390,576	0	0	33,959	424,535
59.00 05900	CARDIAC CATHETERIZATION	601,524	0	0	73,528	675,052
60.00 06000	LABORATORY	2,202,473	32,758	0	1,926	2,237,157
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
64.01 06401	INTRAVENOUS THERAPY	1,648	0	0	296	1,944
65.00 06500	RESPIRATORY THERAPY	257,464	0	0	59,936	317,400
66.00 06600	PHYSICAL THERAPY	127,506	21,076	0	29,550	178,132
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00 06900	ELECTROCARDIOLOGY	229,905	0	0	50,911	280,816
70.00 07000	ELECTROENCEPHALOGRAPHY	1,204,179	0	0	76,849	1,281,028
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,435,245	0	0	0	1,435,245
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	825,116	0	0	0	825,116
73.00 07300	DRUGS CHARGED TO PATIENTS	2,287,108	0	0	0	2,287,108
74.00 07400	RENAL DIALYSIS	0	0	0	0	0
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00 09000	CLINIC	0	0	0	0	0
90.01 09001	CLINIC	155,682	0	0	33,029	188,711
90.02 09002	CLINIC	365,861	0	0	34,243	400,104
91.00 09100	EMERGENCY	0	53,433	0	0	53,433
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	33,049,734	1,986,093	0	2,296,108	32,642,611
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00 19100	RESEARCH	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	355,392	327,340	0	79,783	762,515
193.00 19300	NONPAID WORKERS	0	0	0	0	0
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	33,405,126	2,313,433	0	2,375,891	33,405,126

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.00	6.00	7.00	8.00	9.00		
<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	
5.00	00500	ADMINISTRATIVE & GENERAL	9,265,605				5.00	
6.00	00600	MAINTENANCE & REPAIRS	294,515	1,061,811			6.00	
7.00	00700	OPERATION OF PLANT	25,932	36,887	130,379		7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	9,657	0	0	34,816	8.00	
9.00	00900	HOUSEKEEPING	91,990	2,622	334	93	334,698	9.00
10.00	01000	DIETARY	56,658	22,672	2,884	0	7,423	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	194,153	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	49,271	22,882	2,911	0	7,491	14.00
15.00	01500	PHARMACY	217,963	3,337	424	0	1,092	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	172,072	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	677,778	246,199	31,319	10,668	80,604	30.00
31.00	03100	INTENSIVE CARE UNIT	308,216	60,398	7,683	4,149	19,774	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,429,887	245,894	31,280	19,906	80,505	50.00
51.00	05100	RECOVERY ROOM	415,631	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	13,846	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	831,838	183,626	23,359	0	60,119	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	120,327	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	162,951	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	259,109	0	0	0	0	59.00
60.00	06000	LABORATORY	858,699	17,886	2,275	0	5,856	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	746	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	121,829	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	68,373	11,508	1,464	0	3,768	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	107,787	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	491,703	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	550,897	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	316,708	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	877,872	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	72,434	0	0	0	0	90.01
90.02	09002	CLINIC	153,574	0	0	0	0	90.02
91.00	09100	EMERGENCY	20,509	29,174	3,711	0	9,552	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	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,972,925	883,085	107,644	34,816	276,184	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	292,680	178,726	22,735	0	58,514	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	9,265,605	1,061,811	130,379	34,816	334,698	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150165

Period:  
From 07/01/2013  
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Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	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
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	237,248					10.00
11.00	01100	0	0				11.00
12.00	01200	0	0	0			12.00
13.00	01300	0	0	0	699,976		13.00
14.00	01400	0	0	0	0	210,921	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	159,660	0	0	165,574	0	30.00
31.00	03100	77,588	0	0	97,604	0	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	0	0	259,972	0	50.00
51.00	05100	0	0	0	176,826	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	0	0	0	0	54.00
55.00	05500	0	0	0	0	0	55.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	0	0	60.00
64.00	06400	0	0	0	0	0	64.00
64.01	06401	0	0	0	0	0	64.01
65.00	06500	0	0	0	0	0	65.00
66.00	06600	0	0	0	0	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	210,921	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	09002	0	0	0	0	0	90.02
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	0	0	0	0	113.00
118.00		237,248	0	0	699,976	210,921	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		237,248	0	0	699,976	210,921	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150165

Period:  
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Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS	
	15.00	16.00	17.00	18.00	19.00	
<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
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
6.00 00600 MAINTENANCE & REPAIRS						6.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
12.00 01200 MAINTENANCE OF PERSONNEL						12.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY	790,673					15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	620,368				16.00
17.00 01700 SOCIAL SERVICE	0	0	0			17.00
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0		18.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00 02000 NURSING SCHOOL	0	0	0	0	0	20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	0	14,003	0	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	4,713	0	0	0	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	127,126	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	11,492	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	60,569	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00 05700 CT SCAN	0	37,984	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	44,671	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	23,811	0	0	0	59.00
60.00 06000 LABORATORY	0	117,895	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01 06401 INTRAVENOUS THERAPY	0	3,786	0	0	0	64.01
65.00 06500 RESPIRATORY THERAPY	0	3,010	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	1,034	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	11,821	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	12,299	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	26,372	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	12,410	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	790,673	95,701	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 CLINIC	0	0	0	0	0	90.01
90.02 09002 CLINIC	0	11,671	0	0	0	90.02
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)	790,673	620,368	0	0	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	790,673	620,368	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150165

Period:  
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Cost Center Description	INTERNS & RESIDENTS				PARAMED PRGM	Subtotal	
	NURSING SCHOOL	SERVICES-SALAR	SERVICES-OTHER				
		Y & FRINGES	PRGM COSTS				
20.00	21.00	22.00	23.00	24.00			
<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
5.00 00500	ADMINISTRATIVE & GENERAL						5.00
6.00 00600	MAINTENANCE & REPAIRS						6.00
7.00 00700	OPERATION OF PLANT						7.00
8.00 00800	LAUNDRY & LINEN SERVICE						8.00
9.00 00900	HOUSEKEEPING						9.00
10.00 01000	DIETARY						10.00
11.00 01100	CAFETERIA						11.00
12.00 01200	MAINTENANCE OF PERSONNEL						12.00
13.00 01300	NURSING ADMINISTRATION						13.00
14.00 01400	CENTRAL SERVICES & SUPPLY						14.00
15.00 01500	PHARMACY						15.00
16.00 01600	MEDICAL RECORDS & LIBRARY						16.00
17.00 01700	SOCIAL SERVICE						17.00
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)						18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00 02000	NURSING SCHOOL	0					20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0				21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0			22.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0	0	0		23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	0	0	0	0	3,151,610	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	1,383,117	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	0	0	0	0	5,919,797	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	1,686,787	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	49,919	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	3,326,687	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00 05700	CT SCAN	0	0	0	0	471,798	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	632,157	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	957,972	59.00
60.00 06000	LABORATORY	0	0	0	0	3,239,768	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01 06401	INTRAVENOUS THERAPY	0	0	0	0	6,476	64.01
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	442,239	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	264,279	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	400,424	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	1,785,030	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	2,223,435	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,154,234	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,051,354	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000	CLINIC	0	0	0	0	0	90.00
90.01 09001	CLINIC	0	0	0	0	261,145	90.01
90.02 09002	CLINIC	0	0	0	0	565,349	90.02
91.00 09100	EMERGENCY	0	0	0	0	116,379	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)	0	0	0	0	32,089,956	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	1,315,170	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	0	0	0	33,405,126	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet B  
Part I  
Date/Time Prepared:  
6/3/2014 9:46 am

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	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
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)		18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000	NURSING SCHOOL		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	0	3,151,610
31.00	03100	INTENSIVE CARE UNIT	0	1,383,117
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	0	5,919,797
51.00	05100	RECOVERY ROOM	0	1,686,787
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0
53.00	05300	ANESTHESIOLOGY	0	49,919
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,326,687
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0
57.00	05700	CT SCAN	0	471,798
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	632,157
59.00	05900	CARDIAC CATHETERIZATION	0	957,972
60.00	06000	LABORATORY	0	3,239,768
64.00	06400	INTRAVENOUS THERAPY	0	0
64.01	06401	INTRAVENOUS THERAPY	0	6,476
65.00	06500	RESPIRATORY THERAPY	0	442,239
66.00	06600	PHYSICAL THERAPY	0	264,279
67.00	06700	OCCUPATIONAL THERAPY	0	0
68.00	06800	SPEECH PATHOLOGY	0	0
69.00	06900	ELECTROCARDIOLOGY	0	400,424
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,785,030
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,223,435
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,154,234
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,051,354
74.00	07400	RENAL DIALYSIS	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800	RURAL HEALTH CLINIC	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0
90.00	09000	CLINIC	0	0
90.01	09001	CLINIC	0	261,145
90.02	09002	CLINIC	0	565,349
91.00	09100	EMERGENCY	0	116,379
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	32,089,956
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0
191.00	19100	RESEARCH	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,315,170
193.00	19300	NONPAID WORKERS	0	0
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	33,405,126

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet B  
Part II  
Date/Time Prepared:  
6/3/2014 9:46 am

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
5.00 00500	ADMINISTRATIVE & GENERAL	0	368,707	0	368,707	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	0	67,560	0	67,560	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	4,802	0	4,802	9.00
10.00 01000	DIETARY	0	41,524	0	41,524	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	41,908	0	41,908	14.00
15.00 01500	PHARMACY	0	6,112	0	6,112	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	450,918	0	450,918	30.00
31.00 03100	INTENSIVE CARE UNIT	0	110,621	0	110,621	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	450,359	0	450,359	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	336,315	0	336,315	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	0	32,758	0	32,758	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
64.01 06401	INTRAVENOUS THERAPY	0	0	0	0	64.01
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	21,076	0	21,076	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 09001	CLINIC	0	0	0	0	90.01
90.02 09002	CLINIC	0	0	0	0	90.02
91.00 09100	EMERGENCY	0	53,433	0	53,433	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	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,986,093	0	1,986,093	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	327,340	0	327,340	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	2,313,433	0	2,313,433	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150165	Period: From 07/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 6/3/2014 9:46 am		
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING
		5.00	6.00	7.00	8.00	9.00
<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
5.00	00500	ADMINISTRATIVE & GENERAL	368,707			5.00
6.00	00600	MAINTENANCE & REPAIRS	11,720	11,720		6.00
7.00	00700	OPERATION OF PLANT	1,032	407	68,999	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	384	0	0	384
9.00	00900	HOUSEKEEPING	3,661	29	177	1
10.00	01000	DIETARY	2,255	250	1,526	0
11.00	01100	CAFETERIA	0	0	0	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	7,726	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	1,961	253	1,540	0
15.00	01500	PHARMACY	8,673	37	225	0
16.00	01600	MEDICAL RECORDS & LIBRARY	6,847	0	0	0
17.00	01700	SOCIAL SERVICE	0	0	0	0
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	26,971	2,717	16,574	118
31.00	03100	INTENSIVE CARE UNIT	12,265	667	4,066	46
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	56,900	2,714	16,554	219
51.00	05100	RECOVERY ROOM	16,539	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0
53.00	05300	ANESTHESIOLOGY	551	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,101	2,027	12,362	0
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0
57.00	05700	CT SCAN	4,788	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,484	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	10,311	0	0	0
60.00	06000	LABORATORY	34,170	197	1,204	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0
64.01	06401	INTRAVENOUS THERAPY	30	0	0	0
65.00	06500	RESPIRATORY THERAPY	4,848	0	0	0
66.00	06600	PHYSICAL THERAPY	2,721	127	775	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	4,289	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	19,566	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,922	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,603	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	34,933	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0
90.00	09000	CLINIC	0	0	0	0
90.01	09001	CLINIC	2,882	0	0	0
90.02	09002	CLINIC	6,111	0	0	0
91.00	09100	EMERGENCY	816	322	1,964	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	247
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300	INTEREST EXPENSE				
118.00		SUBTOTALS (SUM OF LINES 1-117)	357,060	9,747	56,967	384
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,647	1,973	12,032	0
193.00	19300	NONPAID WORKERS	0	0	0	0
200.00		Cross Foot Adjustments				
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	368,707	11,720	68,999	384

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150165		Period: From 07/01/2013 To 12/31/2013		Worksheet B Part II Date/Time Prepared: 6/3/2014 9:46 am	
Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	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
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	45,747					10.00
11.00	01100	0	0				11.00
12.00	01200	0	0	0			12.00
13.00	01300	0	0	0	7,726		13.00
14.00	01400	0	0	0	0	45,856	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	30,786	0	0	1,828	0	30.00
31.00	03100	14,961	0	0	1,077	0	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	0	0	2,869	0	50.00
51.00	05100	0	0	0	1,952	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	0	0	0	0	54.00
55.00	05500	0	0	0	0	0	55.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	0	0	60.00
64.00	06400	0	0	0	0	0	64.00
64.01	06401	0	0	0	0	0	64.01
65.00	06500	0	0	0	0	0	65.00
66.00	06600	0	0	0	0	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	45,856	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	09002	0	0	0	0	0	90.02
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	0	0	0	0	113.00
118.00		45,747	0	0	7,726	45,856	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		45,747	0	0	7,726	45,856	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet B  
Part II  
Date/Time Prepared:  
6/3/2014 9:46 am

Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS	
				18.00		
	15.00	16.00	17.00	18.00	19.00	
<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
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
6.00 00600 MAINTENANCE & REPAIRS						6.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
12.00 01200 MAINTENANCE OF PERSONNEL						12.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY	15,075					15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	6,847				16.00
17.00 01700 SOCIAL SERVICE	0	0	0			17.00
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0		18.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00 02000 NURSING SCHOOL	0	0	0	0	0	20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	0	155	0	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	52	0	0	0	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	1,381	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	127	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	672	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00 05700 CT SCAN	0	421	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	495	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	264	0	0	0	59.00
60.00 06000 LABORATORY	0	1,307	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01 06401 INTRAVENOUS THERAPY	0	42	0	0	0	64.01
65.00 06500 RESPIRATORY THERAPY	0	33	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	11	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	131	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	136	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	292	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	138	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	15,075	1,061	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 CLINIC	0	0	0	0	0	90.01
90.02 09002 CLINIC	0	129	0	0	0	90.02
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)	15,075	6,847	0	0	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	15,075	6,847	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet B  
Part II  
Date/Time Prepared:  
6/3/2014 9:46 am

Cost Center Description	INTERNS & RESIDENTS			PARAMED PRGM	Subtotal	
	NURSING SCHOOL	SERVICES-SALAR	SERVICES-OTHER			
		Y & FRINGES	PRGM COSTS			
20.00	21.00	22.00	23.00	24.00		
<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
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)					18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00 02000	NURSING SCHOOL	0				20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD		0			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD			0		22.00
23.00 02300	PARAMED PRGM-(SPECIFY)				0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS				532,156	30.00
31.00 03100	INTENSIVE CARE UNIT				144,267	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM				533,081	50.00
51.00 05100	RECOVERY ROOM				18,618	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM				0	52.00
53.00 05300	ANESTHESIOLOGY				551	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC				386,034	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC				0	55.00
57.00 05700	CT SCAN				5,209	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)				6,979	58.00
59.00 05900	CARDIAC CATHETERIZATION				10,575	59.00
60.00 06000	LABORATORY				69,788	60.00
64.00 06400	INTRAVENOUS THERAPY				0	64.00
64.01 06401	INTRAVENOUS THERAPY				72	64.01
65.00 06500	RESPIRATORY THERAPY				4,881	65.00
66.00 06600	PHYSICAL THERAPY				24,808	66.00
67.00 06700	OCCUPATIONAL THERAPY				0	67.00
68.00 06800	SPEECH PATHOLOGY				0	68.00
69.00 06900	ELECTROCARDIOLOGY				4,420	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY				19,702	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				68,070	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS				12,741	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS				51,069	73.00
74.00 07400	RENAL DIALYSIS				0	74.00
75.00 07500	ASC (NON-DISTINCT PART)				0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC				0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER				0	89.00
90.00 09000	CLINIC				0	90.00
90.01 09001	CLINIC				2,882	90.01
90.02 09002	CLINIC				6,240	90.02
91.00 09100	EMERGENCY				56,782	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	0	1,958,925	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				0	190.00
191.00 19100	RESEARCH				0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES				354,508	192.00
193.00 19300	NONPAID WORKERS				0	193.00
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	0	0	2,313,433	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150165	Period: From 07/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 6/3/2014 9:46 am
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	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
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)		18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000	NURSING SCHOOL		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	0	532,156
31.00	03100	INTENSIVE CARE UNIT	0	144,267
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	0	533,081
51.00	05100	RECOVERY ROOM	0	18,618
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0
53.00	05300	ANESTHESIOLOGY	0	551
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	386,034
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0
57.00	05700	CT SCAN	0	5,209
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	6,979
59.00	05900	CARDIAC CATHETERIZATION	0	10,575
60.00	06000	LABORATORY	0	69,788
64.00	06400	INTRAVENOUS THERAPY	0	0
64.01	06401	INTRAVENOUS THERAPY	0	72
65.00	06500	RESPIRATORY THERAPY	0	4,881
66.00	06600	PHYSICAL THERAPY	0	24,808
67.00	06700	OCCUPATIONAL THERAPY	0	0
68.00	06800	SPEECH PATHOLOGY	0	0
69.00	06900	ELECTROCARDIOLOGY	0	4,420
70.00	07000	ELECTROENCEPHALOGRAPHY	0	19,702
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	68,070
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,741
73.00	07300	DRUGS CHARGED TO PATIENTS	0	51,069
74.00	07400	RENAL DIALYSIS	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800	RURAL HEALTH CLINIC	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0
90.00	09000	CLINIC	0	0
90.01	09001	CLINIC	0	2,882
90.02	09002	CLINIC	0	6,240
91.00	09100	EMERGENCY	0	56,782
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,958,925
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0
191.00	19100	RESEARCH	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	354,508
193.00	19300	NONPAID WORKERS	0	0
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	2,313,433

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet B-1  
Date/Time Prepared:  
6/3/2014 9:46 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	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	132,485				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		132,485			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	10,033,946		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	21,115	21,115	1,624,361	-9,265,605	24,139,521
6.00 00600	MAINTENANCE & REPAIRS	0	0	180,966	0	767,296
7.00 00700	OPERATION OF PLANT	3,869	3,869	0	0	67,560
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	25,531	0	25,159
9.00 00900	HOUSEKEEPING	275	275	149,036	0	239,659
10.00 01000	DIETARY	2,378	2,378	22,167	0	147,611
11.00 01100	CAFETERIA	0	0	0	0	0
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	0	0	404,217	0	505,823
14.00 01400	CENTRAL SERVICES & SUPPLY	2,400	2,400	47,008	0	128,366
15.00 01500	PHARMACY	350	350	356,727	0	567,857
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	298,596	0	448,296
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00 02000	NURSING SCHOOL	0	0	0	0	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	25,823	25,823	1,024,028	0	1,765,805
31.00 03100	INTENSIVE CARE UNIT	6,335	6,335	527,334	0	802,992
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	25,791	25,791	1,355,018	0	3,725,227
51.00 05100	RECOVERY ROOM	0	0	841,071	0	1,082,838
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00 05300	ANESTHESIOLOGY	0	0	0	0	36,073
54.00 05400	RADIOLOGY-DIAGNOSTIC	19,260	19,260	1,044,375	0	2,167,176
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
57.00 05700	CT SCAN	0	0	131,657	0	313,487
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	143,416	0	424,535
59.00 05900	CARDIAC CATHETERIZATION	0	0	310,525	0	675,052
60.00 06000	LABORATORY	1,876	1,876	8,134	0	2,237,157
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
64.01 06401	INTRAVENOUS THERAPY	0	0	1,252	0	1,944
65.00 06500	RESPIRATORY THERAPY	0	0	253,123	0	317,400
66.00 06600	PHYSICAL THERAPY	1,207	1,207	124,796	0	178,132
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00 06900	ELECTROCARDIOLOGY	0	0	215,008	0	280,816
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	324,552	0	1,281,028
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,435,245
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	825,116
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,287,108
74.00 07400	RENAL DIALYSIS	0	0	0	0	0
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00 09000	CLINIC	0	0	0	0	0
90.01 09001	CLINIC	0	0	139,489	0	188,711
90.02 09002	CLINIC	0	0	144,617	0	400,104
91.00 09100	EMERGENCY	3,060	3,060	0	0	53,433
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	113,739	113,739	9,697,004	-9,265,605	23,377,006
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00 19100	RESEARCH	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	18,746	18,746	336,942	0	762,515
193.00 19300	NONPAID WORKERS	0	0	0	0	0
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet B-1  
Date/Time Prepared:  
6/3/2014 9:46 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)		
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00					4.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,313,433	0	2,375,891		9,265,605	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	17.461849	0.000000	0.236785		0.383835	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0		368,707	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.015274	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet B-1  
Date/Time Prepared:  
6/3/2014 9:46 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	111,370					6.00
7.00	00700	3,869	107,501				7.00
8.00	00800	0	0	113,144			8.00
9.00	00900	275	275	301	107,226		9.00
10.00	01000	2,378	2,378	0	2,378	8,834	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	0	0	0	0	0	13.00
14.00	01400	2,400	2,400	0	2,400	0	14.00
15.00	01500	350	350	0	350	0	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	25,823	25,823	34,669	25,823	5,945	30.00
31.00	03100	6,335	6,335	13,482	6,335	2,889	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	25,791	25,791	64,692	25,791	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	19,260	19,260	0	19,260	0	54.00
55.00	05500	0	0	0	0	0	55.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	1,876	1,876	0	1,876	0	60.00
64.00	06400	0	0	0	0	0	64.00
64.01	06401	0	0	0	0	0	64.01
65.00	06500	0	0	0	0	0	65.00
66.00	06600	1,207	1,207	0	1,207	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	09002	0	0	0	0	0	90.02
91.00	09100	3,060	3,060	0	3,060	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	0	0	0	0	0	113.00
118.00		92,624	88,755	113,144	88,480	8,834	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	18,746	18,746	0	18,746	0	192.00
193.00	19300	0	0	0	0	0	193.00
200.00							200.00
201.00							201.00
202.00		1,061,811	130,379	34,816	334,698	237,248	202.00
203.00		9.534085	1.212817	0.307714	3.121426	26.856237	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet B-1

Date/Time Prepared:  
6/3/2014 9:46 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	11,720	68,999	384	8,670	45,747	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.105235	0.641845	0.003394	0.080857	5.178515	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet B-1

Date/Time Prepared:  
6/3/2014 9:46 am

Cost Center Description		CAFETERIA (NUMBER HOUSED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	0					11.00
12.00	01200	0	0				12.00
13.00	01300	0	0	10,700			13.00
14.00	01400	0	0	0	100		14.00
15.00	01500	0	0	0	0	100	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	0	2,531	0	0	30.00
31.00	03100	0	0	1,492	0	0	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	0	3,974	0	0	50.00
51.00	05100	0	0	2,703	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	0	0	0	0	54.00
55.00	05500	0	0	0	0	0	55.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	0	0	60.00
64.00	06400	0	0	0	0	0	64.00
64.01	06401	0	0	0	0	0	64.01
65.00	06500	0	0	0	0	0	65.00
66.00	06600	0	0	0	0	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	100	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	100	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	09002	0	0	0	0	0	90.02
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	0	0	0	0	113.00
118.00		0	0	10,700	100	100	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
200.00							200.00
201.00							201.00
202.00		0	0	699,976	210,921	790,673	202.00
203.00		0.000000	0.000000	65.418318	2,109.210000	7,906.730000	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet B-1

Date/Time Prepared:  
6/3/2014 9:46 am

Cost Center Description		CAFETERIA (NUMBER HOUSED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	0	0	7,726	45,856	15,075	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.722056	458.560000	150.750000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet B-1  
Date/Time Prepared:  
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Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY) (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (GROSS REVENUES)	NURSING SCHOOL (ASSIGNED TIME)	
	16.00	17.00	18.00	19.00	20.00	
<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
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
6.00 00600 MAINTENANCE & REPAIRS						6.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
12.00 01200 MAINTENANCE OF PERSONNEL						12.00
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	122,843,046					16.00
17.00 01700 SOCIAL SERVICE	0	0				17.00
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	0			18.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00 02000 NURSING SCHOOL	0	0	0		0	20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0			21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0			22.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	2,772,846	0	0		0	30.00
31.00 03100 INTENSIVE CARE UNIT	933,361	0	0		0	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	25,170,711	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	2,275,741	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	11,993,951	0	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00 05700 CT SCAN	7,521,507	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	8,845,750	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	4,715,115	0	0	0	0	59.00
60.00 06000 LABORATORY	23,345,602	0	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01 06401 INTRAVENOUS THERAPY	749,721	0	0	0	0	64.01
65.00 06500 RESPIRATORY THERAPY	596,027	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	204,838	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	2,340,867	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	2,435,510	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5,222,277	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2,457,349	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	18,950,734	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 CLINIC	0	0	0	0	0	90.01
90.02 09002 CLINIC	2,311,139	0	0	0	0	90.02
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)	122,843,046	0	0	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet B-1

Date/Time Prepared:  
6/3/2014 9:46 am

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY) (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (GROSS REVENUES)	NURSING SCHOOL (ASSIGNED TIME)	
			16.00			
202.00 Cost to be allocated (per Wkst. B, Part I)	620,368	0	0	0	0	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.005050	0.000000	0.000000	0.000000	0.000000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	6,847	0	0	0	0	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.000056	0.000000	0.000000	0.000000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet B-1  
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Cost Center Description	INTERNS & RESIDENTS			PARAMED PRGM (ASSIGNED TIME)	
	SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)			
	21.00	22.00	23.00		
<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
5.00 00500	ADMINISTRATIVE & GENERAL				5.00
6.00 00600	MAINTENANCE & REPAIRS				6.00
7.00 00700	OPERATION OF PLANT				7.00
8.00 00800	LAUNDRY & LINEN SERVICE				8.00
9.00 00900	HOUSEKEEPING				9.00
10.00 01000	DIETARY				10.00
11.00 01100	CAFETERIA				11.00
12.00 01200	MAINTENANCE OF PERSONNEL				12.00
13.00 01300	NURSING ADMINISTRATION				13.00
14.00 01400	CENTRAL SERVICES & SUPPLY				14.00
15.00 01500	PHARMACY				15.00
16.00 01600	MEDICAL RECORDS & LIBRARY				16.00
17.00 01700	SOCIAL SERVICE				17.00
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)				18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00 02000	NURSING SCHOOL				20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		0		22.00
23.00 02300	PARAMED PRGM-(SPECIFY)			0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00 03000	ADULTS & PEDIATRICS	0	0	0	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000	OPERATING ROOM	0	0	0	50.00
51.00 05100	RECOVERY ROOM	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
57.00 05700	CT SCAN	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000	LABORATORY	0	0	0	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	64.00
64.01 06401	INTRAVENOUS THERAPY	0	0	0	64.01
65.00 06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00 09000	CLINIC	0	0	0	90.00
90.01 09001	CLINIC	0	0	0	90.01
90.02 09002	CLINIC	0	0	0	90.02
91.00 09100	EMERGENCY	0	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	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)	0	0	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	193.00
200.00	Cross Foot Adjustments				200.00
201.00	Negative Cost Centers				201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	0	0	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet B-1  
Date/Time Prepared:  
6/3/2014 9:46 am

Cost Center Description		INTERNS & RESIDENTS			PARAMED PRGM (ASSIGNED TIME)	
		SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)			
		21.00	22.00	23.00		
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	0.000000		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	0	0		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet C  
Part I  
Date/Time Prepared:  
6/3/2014 9:46 am

		Title XVIII		Hospital		PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		3,151,610	0	3,151,610	30.00
31.00	03100 INTENSIVE CARE UNIT		1,383,117	0	1,383,117	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		5,919,797	6,381	5,926,178	50.00
51.00	05100 RECOVERY ROOM		1,686,787	0	1,686,787	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0	0	0	52.00
53.00	05300 ANESTHESIOLOGY		49,919	0	49,919	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		3,326,687	0	3,326,687	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC		0	0	0	55.00
57.00	05700 CT SCAN		471,798	0	471,798	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		632,157	0	632,157	58.00
59.00	05900 CARDIAC CATHETERIZATION		957,972	0	957,972	59.00
60.00	06000 LABORATORY		3,239,768	0	3,239,768	60.00
64.00	06400 INTRAVENOUS THERAPY		0	0	0	64.00
64.01	06401 INTRAVENOUS THERAPY		6,476	0	6,476	64.01
65.00	06500 RESPIRATORY THERAPY	0	442,239	0	442,239	65.00
66.00	06600 PHYSICAL THERAPY	0	264,279	0	264,279	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY		400,424	0	400,424	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		1,785,030	0	1,785,030	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		2,223,435	0	2,223,435	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		1,154,234	0	1,154,234	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		4,051,354	0	4,051,354	73.00
74.00	07400 RENAL DIALYSIS		0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)		0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
90.00	09000 CLINIC		0	0	0	90.00
90.01	09001 CLINIC		261,145	0	261,145	90.01
90.02	09002 CLINIC		565,349	0	565,349	90.02
91.00	09100 EMERGENCY		116,379	0	116,379	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1,146,767	0	1,146,767	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		33,236,723	6,381	33,243,104	200.00
201.00	Less Observation Beds		1,146,767		1,146,767	201.00
202.00	Total (see instructions)		32,089,956	6,381	32,096,337	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet C  
Part I  
Date/Time Prepared:  
6/3/2014 9:46 am

		Title XVIII			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	2,072,832		2,072,832		30.00
31.00	03100	INTENSIVE CARE UNIT	933,361		933,361		31.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	2,376,309	22,794,402	25,170,711	0.235186	50.00
51.00	05100	RECOVERY ROOM	156,513	2,119,228	2,275,741	0.741203	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	363,477	11,630,474	11,993,951	0.277364	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	55.00
57.00	05700	CT SCAN	458,754	7,062,753	7,521,507	0.062727	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	302,152	8,543,598	8,845,750	0.071464	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,367,950	3,347,165	4,715,115	0.203170	59.00
60.00	06000	LABORATORY	1,602,193	21,743,409	23,345,602	0.138774	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
64.01	06401	INTRAVENOUS THERAPY	269	749,452	749,721	0.008638	64.01
65.00	06500	RESPIRATORY THERAPY	546,926	49,101	596,027	0.741978	65.00
66.00	06600	PHYSICAL THERAPY	184,160	20,678	204,838	1.290185	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	357,547	1,983,320	2,340,867	0.171058	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,435,510	2,435,510	0.732918	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,123,315	4,098,962	5,222,277	0.425760	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,168,137	1,289,212	2,457,349	0.469707	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,751,530	17,199,204	18,950,734	0.213783	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.01	09001	CLINIC	0	0	0	0.000000	90.01
90.02	09002	CLINIC	0	2,311,139	2,311,139	0.244619	90.02
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	263,536	436,478	700,014	1.638206	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	15,028,961	107,814,085	122,843,046		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	15,028,961	107,814,085	122,843,046		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet C  
Part I  
Date/Time Prepared:  
6/3/2014 9:46 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.235439			50.00
51.00	05100 RECOVERY ROOM	0.741203			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.277364			54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000			55.00
57.00	05700 CT SCAN	0.062727			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.071464			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.203170			59.00
60.00	06000 LABORATORY	0.138774			60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
64.01	06401 INTRAVENOUS THERAPY	0.008638			64.01
65.00	06500 RESPIRATORY THERAPY	0.741978			65.00
66.00	06600 PHYSICAL THERAPY	1.290185			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.171058			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.732918			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.425760			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.469707			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.213783			73.00
74.00	07400 RENAL DIALYSIS	0.000000			74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000			75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000 CLINIC	0.000000			90.00
90.01	09001 CLINIC	0.000000			90.01
90.02	09002 CLINIC	0.244619			90.02
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.638206			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: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet C  
Part I  
Date/Time Prepared:  
6/3/2014 9:46 am

		Title XIX		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS		3,151,610		0	3,151,610	30.00
31.00	03100 INTENSIVE CARE UNIT		1,383,117		0	1,383,117	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM		5,919,797		6,381	5,926,178	50.00
51.00	05100 RECOVERY ROOM		1,686,787		0	1,686,787	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0		0	0	52.00
53.00	05300 ANESTHESIOLOGY		49,919		0	49,919	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		3,326,687		0	3,326,687	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC		0		0	0	55.00
57.00	05700 CT SCAN		471,798		0	471,798	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		632,157		0	632,157	58.00
59.00	05900 CARDIAC CATHETERIZATION		957,972		0	957,972	59.00
60.00	06000 LABORATORY		3,239,768		0	3,239,768	60.00
64.00	06400 INTRAVENOUS THERAPY		0		0	0	64.00
64.01	06401 INTRAVENOUS THERAPY		6,476		0	6,476	64.01
65.00	06500 RESPIRATORY THERAPY	0	442,239		0	442,239	65.00
66.00	06600 PHYSICAL THERAPY	0	264,279		0	264,279	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0		0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0	0	68.00
69.00	06900 ELECTROCARDIOLOGY		400,424		0	400,424	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		1,785,030		0	1,785,030	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		2,223,435		0	2,223,435	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		1,154,234		0	1,154,234	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		4,051,354		0	4,051,354	73.00
74.00	07400 RENAL DIALYSIS		0		0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)		0		0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC		0		0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0		0	0	89.00
90.00	09000 CLINIC		0		0	0	90.00
90.01	09001 CLINIC		261,145		0	261,145	90.01
90.02	09002 CLINIC		565,349		0	565,349	90.02
91.00	09100 EMERGENCY		116,379		0	116,379	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1,146,767		0	1,146,767	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)		33,236,723	0	6,381	33,243,104	200.00
201.00	Less Observation Beds		1,146,767			1,146,767	201.00
202.00	Total (see instructions)		32,089,956	0	6,381	32,096,337	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet C  
Part I  
Date/Time Prepared:  
6/3/2014 9:46 am

		Title XIX			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	2,072,832		2,072,832			30.00
31.00	03100 INTENSIVE CARE UNIT	933,361		933,361			31.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	2,376,309	22,794,402	25,170,711	0.235186	0.000000	50.00
51.00	05100 RECOVERY ROOM	156,513	2,119,228	2,275,741	0.741203	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	363,477	11,630,474	11,993,951	0.277364	0.000000	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
57.00	05700 CT SCAN	458,754	7,062,753	7,521,507	0.062727	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	302,152	8,543,598	8,845,750	0.071464	0.000000	58.00
59.00	05900 CARDIAC CATHETERIZATION	1,367,950	3,347,165	4,715,115	0.203170	0.000000	59.00
60.00	06000 LABORATORY	1,602,193	21,743,409	23,345,602	0.138774	0.000000	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
64.01	06401 INTRAVENOUS THERAPY	269	749,452	749,721	0.008638	0.000000	64.01
65.00	06500 RESPIRATORY THERAPY	546,926	49,101	596,027	0.741978	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	184,160	20,678	204,838	1.290185	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	357,547	1,983,320	2,340,867	0.171058	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2,435,510	2,435,510	0.732918	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,123,315	4,098,962	5,222,277	0.425760	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,168,137	1,289,212	2,457,349	0.469707	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,751,530	17,199,204	18,950,734	0.213783	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000 CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001 CLINIC	0	0	0	0.000000	0.000000	90.01
90.02	09002 CLINIC	0	2,311,139	2,311,139	0.244619	0.000000	90.02
91.00	09100 EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	263,536	436,478	700,014	1.638206	0.000000	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	15,028,961	107,814,085	122,843,046			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	15,028,961	107,814,085	122,843,046			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150165	Period: From 07/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 6/3/2014 9:46 am
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.235439		50.00
51.00	05100 RECOVERY ROOM	0.741203		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.277364		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000		55.00
57.00	05700 CT SCAN	0.062727		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.071464		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.203170		59.00
60.00	06000 LABORATORY	0.138774		60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
64.01	06401 INTRAVENOUS THERAPY	0.008638		64.01
65.00	06500 RESPIRATORY THERAPY	0.741978		65.00
66.00	06600 PHYSICAL THERAPY	1.290185		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.171058		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.732918		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.425760		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.469707		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.213783		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000		75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 CLINIC	0.000000		90.01
90.02	09002 CLINIC	0.244619		90.02
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.638206		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
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: 150165

Period: From 07/01/2013 To 12/31/2013

Worksheet C Part II Date/Time Prepared: 6/3/2014 9:46 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	5,919,797	533,081	5,386,716	0	0	50.00
51.00	05100 RECOVERY ROOM	1,686,787	18,618	1,668,169	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	49,919	551	49,368	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,326,687	386,034	2,940,653	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700 CT SCAN	471,798	5,209	466,589	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	632,157	6,979	625,178	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	957,972	10,575	947,397	0	0	59.00
60.00	06000 LABORATORY	3,239,768	69,788	3,169,980	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401 INTRAVENOUS THERAPY	6,476	72	6,404	0	0	64.01
65.00	06500 RESPIRATORY THERAPY	442,239	4,881	437,358	0	0	65.00
66.00	06600 PHYSICAL THERAPY	264,279	24,808	239,471	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	400,424	4,420	396,004	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1,785,030	19,702	1,765,328	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,223,435	68,070	2,155,365	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,154,234	12,741	1,141,493	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,051,354	51,069	4,000,285	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 CLINIC	261,145	2,882	258,263	0	0	90.01
90.02	09002 CLINIC	565,349	6,240	559,109	0	0	90.02
91.00	09100 EMERGENCY	116,379	56,782	59,597	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,146,767	193,634	953,133	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)	28,701,996	1,476,136	27,225,860	0	0	200.00
201.00	Less Observation Beds	1,146,767	193,634	953,133	0	0	201.00
202.00	Total (line 200 minus line 201)	27,555,229	1,282,502	26,272,727	0	0	202.00

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

Provider CCN: 150165

Period: From 07/01/2013 To 12/31/2013

Worksheet C Part II Date/Time Prepared: 6/3/2014 9:46 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		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	5,919,797	25,170,711	0.235186		50.00
51.00	05100 RECOVERY ROOM	1,686,787	2,275,741	0.741203		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	49,919	0	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,326,687	11,993,951	0.277364		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0.000000		55.00
57.00	05700 CT SCAN	471,798	7,521,507	0.062727		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	632,157	8,845,750	0.071464		58.00
59.00	05900 CARDIAC CATHETERIZATION	957,972	4,715,115	0.203170		59.00
60.00	06000 LABORATORY	3,239,768	23,345,602	0.138774		60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000		64.00
64.01	06401 INTRAVENOUS THERAPY	6,476	749,721	0.008638		64.01
65.00	06500 RESPIRATORY THERAPY	442,239	596,027	0.741978		65.00
66.00	06600 PHYSICAL THERAPY	264,279	204,838	1.290185		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	400,424	2,340,867	0.171058		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1,785,030	2,435,510	0.732918		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,223,435	5,222,277	0.425760		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,154,234	2,457,349	0.469707		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,051,354	18,950,734	0.213783		73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000		75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000		89.00
90.00	09000 CLINIC	0	0	0.000000		90.00
90.01	09001 CLINIC	261,145	0	0.000000		90.01
90.02	09002 CLINIC	565,349	2,311,139	0.244619		90.02
91.00	09100 EMERGENCY	116,379	0	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,146,767	700,014	1.638206		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (sum of lines 50 thru 199)	28,701,996	119,836,853			200.00
201.00	Less Observation Beds	1,146,767	0			201.00
202.00	Total (line 200 minus line 201)	27,555,229	119,836,853			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150165		Period: From 07/01/2013 To 12/31/2013		Worksheet D Part I Date/Time Prepared: 6/3/2014 9:46 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	532,156	0	532,156	1,965	270.82	30.00
31.00	INTENSIVE CARE UNIT	144,267		144,267	641	225.07	31.00
200.00	Total (Lines 30-199)	676,423		676,423	2,606		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	884	239,405				
31.00	INTENSIVE CARE UNIT	68	15,305				
200.00	Total (Lines 30-199)	952	254,710				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet D  
Part II  
Date/Time Prepared:  
6/3/2014 9:46 am

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	533,081	25,170,711	0.021179	912,430	19,324	50.00
51.00	05100	RECOVERY ROOM	18,618	2,275,741	0.008181	59,193	484	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	551	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	386,034	11,993,951	0.032186	231,633	7,455	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
57.00	05700	CT SCAN	5,209	7,521,507	0.000693	293,917	204	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,979	8,845,750	0.000789	89,702	71	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,575	4,715,115	0.002243	696,659	1,563	59.00
60.00	06000	LABORATORY	69,788	23,345,602	0.002989	901,944	2,696	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	72	749,721	0.000096	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	4,881	596,027	0.008189	280,824	2,300	65.00
66.00	06600	PHYSICAL THERAPY	24,808	204,838	0.121110	114,066	13,815	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,420	2,340,867	0.001888	160,771	304	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	19,702	2,435,510	0.008089	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	68,070	5,222,277	0.013035	281,907	3,675	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,741	2,457,349	0.005185	634,439	3,290	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	51,069	18,950,734	0.002695	688,256	1,855	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	CLINIC	2,882	0	0.000000	0	0	90.01
90.02	09002	CLINIC	6,240	2,311,139	0.002700	0	0	90.02
91.00	09100	EMERGENCY	56,782	0	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	193,634	700,014	0.276614	94,586	26,164	92.00
200.00		Total (lines 50-199)	1,476,136	119,836,853		5,440,327	83,200	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150165		Period: From 07/01/2013 To 12/31/2013		Worksheet D Part III Date/Time Prepared: 6/3/2014 9:46 am	
Cost Center Description			Title XVIII		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
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
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	1,965	0.00	884	0		30.00
31.00	03100	INTENSIVE CARE UNIT	641	0.00	68	0		31.00
200.00		Total (lines 30-199)	2,606		952	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet D  
Part IV  
Date/Time Prepared:  
6/3/2014 9:46 am

Cost Center Description		Title XVIII				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	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150165	Period: From 07/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 6/3/2014 9:46 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		Inpatient Program Charges	PPS
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)			
		6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	25,170,711	0.000000	0.000000	912,430	50.00
51.00	05100	RECOVERY ROOM	0	2,275,741	0.000000	0.000000	59,193	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,993,951	0.000000	0.000000	231,633	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
57.00	05700	CT SCAN	0	7,521,507	0.000000	0.000000	293,917	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	8,845,750	0.000000	0.000000	89,702	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	4,715,115	0.000000	0.000000	696,659	59.00
60.00	06000	LABORATORY	0	23,345,602	0.000000	0.000000	901,944	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	749,721	0.000000	0.000000	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	596,027	0.000000	0.000000	280,824	65.00
66.00	06600	PHYSICAL THERAPY	0	204,838	0.000000	0.000000	114,066	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,340,867	0.000000	0.000000	160,771	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,435,510	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,222,277	0.000000	0.000000	281,907	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,457,349	0.000000	0.000000	634,439	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18,950,734	0.000000	0.000000	688,256	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	CLINIC	0	0	0.000000	0.000000	0	90.01
90.02	09002	CLINIC	0	2,311,139	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	0	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	700,014	0.000000	0.000000	94,586	92.00
200.00		Total (lines 50-199)	0	119,836,853			5,440,327	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet D  
Part IV  
Date/Time Prepared:  
6/3/2014 9:46 am

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		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	5,988,920	0		50.00
51.00	05100 RECOVERY ROOM	0	501,330	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	3,058,941	0		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0		55.00
57.00	05700 CT SCAN	0	2,379,227	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1,814,951	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	1,439,114	0		59.00
60.00	06000 LABORATORY	0	756,481	0		60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0		64.00
64.01	06401 INTRAVENOUS THERAPY	0	18,027	0		64.01
65.00	06500 RESPIRATORY THERAPY	0	15,270	0		65.00
66.00	06600 PHYSICAL THERAPY	0	3,508	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	678,357	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	357,226	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	730,013	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	473,393	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3,884,208	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0		75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000 CLINIC	0	0	0		90.00
90.01	09001 CLINIC	0	0	0		90.01
90.02	09002 CLINIC	0	1,167,922	0		90.02
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	56,664	0		92.00
200.00	Total (lines 50-199)	0	23,323,552	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150165	Period: From 07/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 6/3/2014 9:46 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	0.235186	5,988,920	0	0	1,408,510	50.00
51.00	05100	RECOVERY ROOM	0.741203	501,330	0	0	371,587	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.277364	3,058,941	0	0	848,440	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
57.00	05700	CT SCAN	0.062727	2,379,227	0	0	149,242	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.071464	1,814,951	0	0	129,704	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.203170	1,439,114	0	0	292,385	59.00
60.00	06000	LABORATORY	0.138774	756,481	0	0	104,980	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0.008638	18,027	0	0	156	64.01
65.00	06500	RESPIRATORY THERAPY	0.741978	15,270	0	0	11,330	65.00
66.00	06600	PHYSICAL THERAPY	1.290185	3,508	0	0	4,526	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.171058	678,357	0	0	116,038	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.732918	357,226	0	0	261,817	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.425760	730,013	0	0	310,810	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.469707	473,393	0	0	222,356	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.213783	3,884,208	0	0	830,378	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.244619	1,167,922	0	0	285,696	90.02
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.638206	56,664	0	0	92,827	92.00
200.00		Subtotal (see instructions)		23,323,552	0	0	5,440,782	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		23,323,552	0	0	5,440,782	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150165	Period: From 07/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 6/3/2014 9:46 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
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	CLINIC	0	0	90.01
90.02	09002	CLINIC	0	0	90.02
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150165		Period: From 07/01/2013 To 12/31/2013		Worksheet D Part I Date/Time Prepared: 6/3/2014 9:46 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	532,156	0	532,156	1,965	270.82	30.00
31.00	INTENSIVE CARE UNIT	144,267		144,267	641	225.07	31.00
200.00	Total (Lines 30-199)	676,423		676,423	2,606		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	23	6,229				
31.00	INTENSIVE CARE UNIT	8	1,801				
200.00	Total (Lines 30-199)	31	8,030				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150165	Period: From 07/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 6/3/2014 9:46 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	533,081	25,170,711	0.021179	0	0	50.00
51.00	05100	RECOVERY ROOM	18,618	2,275,741	0.008181	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	551	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	386,034	11,993,951	0.032186	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
57.00	05700	CT SCAN	5,209	7,521,507	0.000693	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,979	8,845,750	0.000789	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,575	4,715,115	0.002243	0	0	59.00
60.00	06000	LABORATORY	69,788	23,345,602	0.002989	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	72	749,721	0.000096	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	4,881	596,027	0.008189	0	0	65.00
66.00	06600	PHYSICAL THERAPY	24,808	204,838	0.121110	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,420	2,340,867	0.001888	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	19,702	2,435,510	0.008089	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	68,070	5,222,277	0.013035	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,741	2,457,349	0.005185	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	51,069	18,950,734	0.002695	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	CLINIC	2,882	0	0.000000	0	0	90.01
90.02	09002	CLINIC	6,240	2,311,139	0.002700	0	0	90.02
91.00	09100	EMERGENCY	56,782	0	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	193,634	700,014	0.276614	0	0	92.00
200.00		Total (lines 50-199)	1,476,136	119,836,853		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150165		Period: From 07/01/2013 To 12/31/2013		Worksheet D Part III Date/Time Prepared: 6/3/2014 9:46 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
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
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	1,965	0.00	23	0		30.00
31.00	03100	INTENSIVE CARE UNIT	641	0.00	8	0		31.00
200.00		Total (lines 30-199)	2,606		31	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet D  
Part IV  
Date/Time Prepared:  
6/3/2014 9:46 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	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet D  
Part IV  
Date/Time Prepared:  
6/3/2014 9:46 am

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		
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	0	25,170,711	0.000000	0.000000	0	50.00	
51.00	05100	RECOVERY ROOM	0	2,275,741	0.000000	0.000000	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,993,951	0.000000	0.000000	0	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00	
57.00	05700	CT SCAN	0	7,521,507	0.000000	0.000000	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	8,845,750	0.000000	0.000000	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	4,715,115	0.000000	0.000000	0	59.00	
60.00	06000	LABORATORY	0	23,345,602	0.000000	0.000000	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00	
64.01	06401	INTRAVENOUS THERAPY	0	749,721	0.000000	0.000000	0	64.01	
65.00	06500	RESPIRATORY THERAPY	0	596,027	0.000000	0.000000	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	204,838	0.000000	0.000000	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	2,340,867	0.000000	0.000000	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,435,510	0.000000	0.000000	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,222,277	0.000000	0.000000	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,457,349	0.000000	0.000000	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18,950,734	0.000000	0.000000	0	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00	
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>									
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00	
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00	
90.01	09001	CLINIC	0	0	0.000000	0.000000	0	90.01	
90.02	09002	CLINIC	0	2,311,139	0.000000	0.000000	0	90.02	
91.00	09100	EMERGENCY	0	0	0.000000	0.000000	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	700,014	0.000000	0.000000	0	92.00	
200.00		Total (lines 50-199)	0	119,836,853			0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet D  
Part IV  
Date/Time Prepared:  
6/3/2014 9:46 am

Cost Center Description		Title XIX			Hospital	PPS
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0		55.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0		64.00
64.01	06401 INTRAVENOUS THERAPY	0	0	0		64.01
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0		75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000 CLINIC	0	0	0		90.00
90.01	09001 CLINIC	0	0	0		90.01
90.02	09002 CLINIC	0	0	0		90.02
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00	Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150165	Period: From 07/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 6/3/2014 9:46 am
Cost Center Description		Title XVIII	Hospital	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)		1,965	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,965	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)		1,250	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)		884	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)		3,151,610	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,151,610	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)		3,151,610	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)		1,603.87	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,417,821	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)		1,417,821	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150165		Period: From 07/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 6/3/2014 9:46 am	
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)	PPS
NURSERY (title V & XIX only)		1.00	2.00	3.00	4.00	5.00	
42.00	Intensive Care Type Inpatient Hospital Units						42.00
43.00	INTENSIVE CARE UNIT	1,383,117	641	2,157.75	68	146,727	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)					1,717,641	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,282,189	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					254,710	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					83,200	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					337,910	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,944,279	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00	Total observation bed days (see instructions)					715	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,603.87	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,146,767	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150165		Period: From 07/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 6/3/2014 9:46 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	532,156	3,151,610	0.168852	1,146,767	193,634	90.00
91.00	Nursing School cost	0	3,151,610	0.000000	1,146,767	0	91.00
92.00	Allied health cost	0	3,151,610	0.000000	1,146,767	0	92.00
93.00	All other Medical Education	0	3,151,610	0.000000	1,146,767	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150165	Period: From 07/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 6/3/2014 9:46 am
Cost Center Description		Title XIX	Hospital	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)		1,965	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,965	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)		1,250	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)		23	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)		3,151,610	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,151,610	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)		3,151,610	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)		1,603.87	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		36,889	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)		36,889	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150165	Period: From 07/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 6/3/2014 9:46 am
Cost Center Description			Title XIX	Hospital	PPS
	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	1,383,117	641	2,157.75	8	17,262
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
Cost Center Description					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				0
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				54,151
PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				8,030
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				0
52.00	Total Program excludable cost (sum of lines 50 and 51)				8,030
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				46,121
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				0
55.00	Target amount per discharge				0.00
56.00	Target amount (line 54 x line 55)				0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0
58.00	Bonus payment (see instructions)				0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00
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
62.00	Relief payment (see instructions)				0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0
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
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0
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)				715
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,603.87
89.00	Observation bed cost (line 87 x line 88) (see instructions)				1,146,767

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150165		Period: From 07/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 6/3/2014 9:46 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	532,156	3,151,610	0.168852	1,146,767	193,634	90.00
91.00	Nursing School cost	0	3,151,610	0.000000	1,146,767	0	91.00
92.00	Allied health cost	0	3,151,610	0.000000	1,146,767	0	92.00
93.00	All other Medical Education	0	3,151,610	0.000000	1,146,767	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150165	Period: From 07/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 6/3/2014 9:46 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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		806,172		30.00
31.00	03100 INTENSIVE CARE UNIT		455,023		31.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.235439	912,430	214,822	50.00
51.00	05100 RECOVERY ROOM	0.741203	59,193	43,874	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.277364	231,633	64,247	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
57.00	05700 CT SCAN	0.062727	293,917	18,437	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.071464	89,702	6,410	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.203170	696,659	141,540	59.00
60.00	06000 LABORATORY	0.138774	901,944	125,166	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
64.01	06401 INTRAVENOUS THERAPY	0.008638	0	0	64.01
65.00	06500 RESPIRATORY THERAPY	0.741978	280,824	208,365	65.00
66.00	06600 PHYSICAL THERAPY	1.290185	114,066	147,166	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.171058	160,771	27,501	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.732918	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.425760	281,907	120,025	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.469707	634,439	298,000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.213783	688,256	147,137	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	09001 CLINIC	0.000000	0	0	90.01
90.02	09002 CLINIC	0.244619	0	0	90.02
91.00	09100 EMERGENCY	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.638206	94,586	154,951	92.00
200.00	Total (sum of lines 50-94 and 96-98)		5,440,327	1,717,641	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)		5,440,327		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150165	Period: From 07/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 6/3/2014 9:46 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)		821,595	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		905,051	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)		278,318	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)		28.11	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)		1.22	31.00
32.00	Sum of lines 30 and 31		1.22	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: 150165	Period: From 07/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 6/3/2014 9:46 am	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1	On/After October 1	
<b>Uncompensated Care Adjustment</b>					
35.00	Total uncompensated care amount (see instructions)			0	35.00
35.01	Factor 3 (see instructions)			0.00000000	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)			2,004,964	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)			2,004,964	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)			212,256	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)			2,217,220	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			2,217,220	61.00
62.00	Deductibles billed to program beneficiaries			175,232	62.00
63.00	Coinurance billed to program beneficiaries			296	63.00
64.00	Allowable bad debts (see instructions)			24,273	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			15,777	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,316	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			2,057,469	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)			2,841	70.93
70.94	Hospital readmissions reduction adjustment (see instructions)			-1,044	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: 150165	Period: From 07/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 6/3/2014 9:46 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)		2,059,266		71.00
71.01	Sequestration adjustment (see instructions)		41,185		71.01
72.00	Interim payments		2,002,617		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		15,464		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: 150165	Period: From 07/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 6/3/2014 9:46 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		5,440,782	2.00
3.00	PPS payments		4,534,130	3.00
4.00	Outlier payment (see instructions)		18,584	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
<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)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		4,552,714	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)		1,070,433	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		3,482,281	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		3,482,281	30.00
31.00	Primary payer payments		2,852	31.00
32.00	Subtotal (line 30 minus line 31)		3,479,429	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)		39,298	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		25,544	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		804	36.00
37.00	Subtotal (see instructions)		3,504,973	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)		3,504,973	40.00
40.01	Sequestration adjustment (see instructions)		70,099	40.01
41.00	Interim payments		3,410,401	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		24,473	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: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet E-1  
Part I  
Date/Time Prepared:  
6/3/2014 9:46 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		2,002,617		3,410,401	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)		2,002,617		3,410,401	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		15,464		24,473	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		2,018,081		3,434,874	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: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet E-1  
Part II  
Date/Time Prepared:  
6/3/2014 9:46 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			464 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			952 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			10 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			1,891 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			122,843,046 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			17,400 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)			508,700 8.00
9.00	Sequestration adjustment amount (see instructions)			10,174 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			498,526 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)			498,526 32.00

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

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet G

Date/Time Prepared:  
6/3/2014 9:46 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	29,227,560	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	18,792,098	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,120,849	0	0	0	6.00
7.00	Inventory	1,421,460	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	17,890,533	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)	62,210,802	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	7,869,989	0	0	0	12.00
13.00	Land improvements	973,559	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	31,036,128	0	0	0	15.00
16.00	Accumulated depreciation	-18,648,100	0	0	0	16.00
17.00	Leasehold improvements	6,386,197	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	21,018,450	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	48,636,223	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	3,803,554	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,803,554	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	114,650,579	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	3,903,533	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,064,320	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	627,470	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	40,141,010	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	45,736,333	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	1,874,299	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	392,297	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,266,596	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	48,002,929	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	66,647,650				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)	66,647,650	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	114,650,579	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet G-1

Date/Time Prepared:  
6/3/2014 9:46 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		49,608,581		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		89,589,974		0	2.00
3.00	Total (sum of line 1 and line 2)		139,198,555		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		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)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		139,198,555		0	11.00
12.00	DEDUCTIONS	72,550,905		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)		72,550,905		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		66,647,650		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	DEDUCTIONS		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: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
6/3/2014 9:46 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	2,072,832		2,072,832	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,072,832		2,072,832	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	933,361		933,361	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)	933,361		933,361	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,006,193		3,006,193	17.00
18.00	Ancillary services	11,759,233	105,066,468	116,825,701	18.00
19.00	Outpatient services	263,536	2,747,617	3,011,153	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	NON-REIMBURSEABLE	0	313,323	313,323	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	15,028,962	108,127,408	123,156,370	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		33,566,396		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		33,566,396		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150165

Period:  
From 07/01/2013  
To 12/31/2013

Worksheet G-3

Date/Time Prepared:  
6/3/2014 9:46 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	123,156,370	1.00
2.00	Less contractual allowances and discounts on patients' accounts	0	2.00
3.00	Net patient revenues (line 1 minus line 2)	123,156,370	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	33,566,396	4.00
5.00	Net income from service to patients (line 3 minus line 4)	89,589,974	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	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
25.00	Total other income (sum of lines 6-24)		25.00
26.00	Total (line 5 plus line 25)	89,589,974	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)	89,589,974	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150165	Period: From 07/01/2013 To 12/31/2013	Worksheet L Parts I-III Date/Time Prepared: 6/3/2014 9:46 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		137,662	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		74,594	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)		10.28	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)		212,256	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<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