

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: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet 5 Parts I-III Date/Time Prepared: 5/27/2014 4:34 pm
--	----------------------	---	--

PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare utilization. Enter "F" for full or "L" for low.	Date: 5/27/2014 Time: 4:34 pm
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 ST. FRANCIS H&H-MOORESVILLE (150057) for the cost reporting period beginning 01/01/2013 and ending 12/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 5/27/2014 Time: 4:34 pm
 Err10mjto68R618qknuTgk2FH2w.0
 Ye1260dKutVzIDwDb0qaRnof0Geuc.
 X6161LTAdm08HpFz
 PI: Date: 5/27/2014 Time: 4:34 pm
 0o06JZiYq6LITsN7NKdM1w61NUOI10
 aFQ8N07ykhXF8hnIike3LumUdd7rju
 4Nvr0bRdgg03aCaQ

(Signed) *K. Lantz*
 Officer or Administrator of Provider(s)
Regional CFO
 Title
5/29/14
 Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	54,082	89,006	90,169	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	0		0	6.00
200.00 Total	0	54,082	89,006	90,169	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: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/27/2014 12:14 pm
---	--	----------------------	---	--

1.00	Hospital and Hospital Health Care Complex Address:	2.00	3.00	4.00	1.00
1.00	Street: 1201 HADLEY ROAD	PO Box:	Zip Code: 46158-	County: MORGAN	2.00
2.00	City: MOORESVILLE	State: IN			

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

Hospital and Hospital-Based Component Identification:										
3.00	Hospital	ST. FRANCIS H&H-MOORESVILLE	150057	26900	1	07/01/1996	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

						From:	To:		
						1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2013	12/31/2013	20.00	
21.00	Type of Control (see instructions)					2		21.00	

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/27/2014 12:14 pm		
		Urban/Rural S	Date of Geogr			
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0			35.00	
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	0			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.	0			38.00	
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N		39.00	
		V	XVII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N			57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	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		
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		
61.04	Enter the number of unweighted primary care/surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150057		Period: From 01/01/2013 To 12/31/2013		Worksheet S-2 Part I Date/Time Prepared: 5/27/2014 12:14 pm	
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20	
					1.00		
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings							
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00	
				Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/27/2014 12:14 pm																																																																																																																						
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))																																																																																																																						
		1.00	2.00	3.00																																																																																																																						
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010																																																																																																																										
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00																																																																																																																					
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))																																																																																																																				
		1.00	2.00	3.00	4.00	5.00																																																																																																																				
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000																																																																																																																				
<table border="1"> <thead> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> <th>3.00</th> </tr> </thead> <tbody> <tr> <td colspan="2">Inpatient Psychiatric Facility PPS</td> <td></td> <td></td> <td></td> </tr> <tr> <td>70.00</td> <td>Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.</td> <td></td> <td></td> <td>N</td> </tr> <tr> <td>71.00</td> <td>If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period 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)</td> <td></td> <td></td> <td>0</td> </tr> <tr> <td colspan="6">Inpatient Rehabilitation Facility PPS</td> </tr> <tr> <td>75.00</td> <td>Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.</td> <td></td> <td></td> <td>N</td> </tr> <tr> <td>76.00</td> <td>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)</td> <td></td> <td></td> <td>0</td> </tr> <tr> <td colspan="6"> <table border="1"> <thead> <tr> <th colspan="2"></th> <th>1.00</th> </tr> </thead> <tbody> <tr> <td colspan="2">Long Term Care Hospital PPS</td> <td></td> </tr> <tr> <td>80.00</td> <td>Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.</td> <td>N</td> </tr> <tr> <td colspan="6">TEFRA Providers</td> </tr> <tr> <td>85.00</td> <td>Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.</td> <td></td> <td></td> <td>N</td> </tr> <tr> <td>86.00</td> <td>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.</td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="6"> <table border="1"> <thead> <tr> <th colspan="2"></th> <th>V</th> <th>XIX</th> </tr> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> </tr> </thead> <tbody> <tr> <td colspan="6">Title V and XIX Services</td> </tr> <tr> <td>90.00</td> <td>Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>Y</td> </tr> <tr> <td>91.00</td> <td>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.</td> <td></td> <td>N</td> <td>Y</td> </tr> <tr> <td>92.00</td> <td>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.</td> <td></td> <td></td> <td>N</td> </tr> <tr> <td>93.00</td> <td>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.</td> <td></td> <td>N</td> <td>N</td> </tr> <tr> <td>94.00</td> <td>Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>N</td> </tr> <tr> <td>95.00</td> <td>If line 94 is "Y", enter the reduction percentage in the applicable column.</td> <td></td> <td>0.00</td> <td>0.00</td> </tr> </tbody> </table> </td> </tr> </tbody> </table> </td></tr></tbody></table>								1.00	2.00	3.00	Inpatient Psychiatric Facility PPS					70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N	71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period 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	Inpatient Rehabilitation Facility PPS						75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N	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	<table border="1"> <thead> <tr> <th colspan="2"></th> <th>1.00</th> </tr> </thead> <tbody> <tr> <td colspan="2">Long Term Care Hospital PPS</td> <td></td> </tr> <tr> <td>80.00</td> <td>Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.</td> <td>N</td> </tr> <tr> <td colspan="6">TEFRA Providers</td> </tr> <tr> <td>85.00</td> <td>Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.</td> <td></td> <td></td> <td>N</td> </tr> <tr> <td>86.00</td> <td>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.</td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="6"> <table border="1"> <thead> <tr> <th colspan="2"></th> <th>V</th> <th>XIX</th> </tr> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> </tr> </thead> <tbody> <tr> <td colspan="6">Title V and XIX Services</td> </tr> <tr> <td>90.00</td> <td>Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>Y</td> </tr> <tr> <td>91.00</td> <td>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.</td> <td></td> <td>N</td> <td>Y</td> </tr> <tr> <td>92.00</td> <td>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.</td> <td></td> <td></td> <td>N</td> </tr> <tr> <td>93.00</td> <td>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.</td> <td></td> <td>N</td> <td>N</td> </tr> <tr> <td>94.00</td> <td>Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>N</td> </tr> <tr> <td>95.00</td> <td>If line 94 is "Y", enter the reduction percentage in the applicable column.</td> <td></td> <td>0.00</td> <td>0.00</td> </tr> </tbody> </table> </td> </tr> </tbody> </table>								1.00	Long Term Care Hospital PPS			80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	TEFRA Providers						85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	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.				<table border="1"> <thead> <tr> <th colspan="2"></th> <th>V</th> <th>XIX</th> </tr> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> </tr> </thead> <tbody> <tr> <td colspan="6">Title V and XIX Services</td> </tr> <tr> <td>90.00</td> <td>Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>Y</td> </tr> <tr> <td>91.00</td> <td>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.</td> <td></td> <td>N</td> <td>Y</td> </tr> <tr> <td>92.00</td> <td>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.</td> <td></td> <td></td> <td>N</td> </tr> <tr> <td>93.00</td> <td>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.</td> <td></td> <td>N</td> <td>N</td> </tr> <tr> <td>94.00</td> <td>Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>N</td> </tr> <tr> <td>95.00</td> <td>If line 94 is "Y", enter the reduction percentage in the applicable column.</td> <td></td> <td>0.00</td> <td>0.00</td> </tr> </tbody> </table>								V	XIX			1.00	2.00	Title V and XIX Services						90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	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	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	94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00
		1.00	2.00	3.00																																																																																																																						
Inpatient Psychiatric Facility PPS																																																																																																																										
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N																																																																																																																						
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period 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																																																																																																																						
Inpatient Rehabilitation Facility PPS																																																																																																																										
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N																																																																																																																						
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																																																																																																																						
<table border="1"> <thead> <tr> <th colspan="2"></th> <th>1.00</th> </tr> </thead> <tbody> <tr> <td colspan="2">Long Term Care Hospital PPS</td> <td></td> </tr> <tr> <td>80.00</td> <td>Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.</td> <td>N</td> </tr> <tr> <td colspan="6">TEFRA Providers</td> </tr> <tr> <td>85.00</td> <td>Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.</td> <td></td> <td></td> <td>N</td> </tr> <tr> <td>86.00</td> <td>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.</td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="6"> <table border="1"> <thead> <tr> <th colspan="2"></th> <th>V</th> <th>XIX</th> </tr> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> </tr> </thead> <tbody> <tr> <td colspan="6">Title V and XIX Services</td> </tr> <tr> <td>90.00</td> <td>Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>Y</td> </tr> <tr> <td>91.00</td> <td>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.</td> <td></td> <td>N</td> <td>Y</td> </tr> <tr> <td>92.00</td> <td>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.</td> <td></td> <td></td> <td>N</td> </tr> <tr> <td>93.00</td> <td>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.</td> <td></td> <td>N</td> <td>N</td> </tr> <tr> <td>94.00</td> <td>Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>N</td> </tr> <tr> <td>95.00</td> <td>If line 94 is "Y", enter the reduction percentage in the applicable column.</td> <td></td> <td>0.00</td> <td>0.00</td> </tr> </tbody> </table> </td> </tr> </tbody> </table>								1.00	Long Term Care Hospital PPS			80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	TEFRA Providers						85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	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.				<table border="1"> <thead> <tr> <th colspan="2"></th> <th>V</th> <th>XIX</th> </tr> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> </tr> </thead> <tbody> <tr> <td colspan="6">Title V and XIX Services</td> </tr> <tr> <td>90.00</td> <td>Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>Y</td> </tr> <tr> <td>91.00</td> <td>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.</td> <td></td> <td>N</td> <td>Y</td> </tr> <tr> <td>92.00</td> <td>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.</td> <td></td> <td></td> <td>N</td> </tr> <tr> <td>93.00</td> <td>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.</td> <td></td> <td>N</td> <td>N</td> </tr> <tr> <td>94.00</td> <td>Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>N</td> </tr> <tr> <td>95.00</td> <td>If line 94 is "Y", enter the reduction percentage in the applicable column.</td> <td></td> <td>0.00</td> <td>0.00</td> </tr> </tbody> </table>								V	XIX			1.00	2.00	Title V and XIX Services						90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	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	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	94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00																																										
		1.00																																																																																																																								
Long Term Care Hospital PPS																																																																																																																										
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N																																																																																																																								
TEFRA Providers																																																																																																																										
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N																																																																																																																						
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.																																																																																																																									
<table border="1"> <thead> <tr> <th colspan="2"></th> <th>V</th> <th>XIX</th> </tr> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> </tr> </thead> <tbody> <tr> <td colspan="6">Title V and XIX Services</td> </tr> <tr> <td>90.00</td> <td>Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>Y</td> </tr> <tr> <td>91.00</td> <td>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.</td> <td></td> <td>N</td> <td>Y</td> </tr> <tr> <td>92.00</td> <td>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.</td> <td></td> <td></td> <td>N</td> </tr> <tr> <td>93.00</td> <td>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.</td> <td></td> <td>N</td> <td>N</td> </tr> <tr> <td>94.00</td> <td>Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>N</td> </tr> <tr> <td>95.00</td> <td>If line 94 is "Y", enter the reduction percentage in the applicable column.</td> <td></td> <td>0.00</td> <td>0.00</td> </tr> </tbody> </table>								V	XIX			1.00	2.00	Title V and XIX Services						90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	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	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	94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00																																																																									
		V	XIX																																																																																																																							
		1.00	2.00																																																																																																																							
Title V and XIX Services																																																																																																																										
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y																																																																																																																						
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	Y																																																																																																																						
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																																																																																																																						
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																																																																																																																						
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N																																																																																																																						
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00																																																																																																																						

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/27/2014 12:14 pm		
		V	XIX			
		1.00	2.00			
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00	
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N			105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00	
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	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.	N			117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00	
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	93,480	0	105,041		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	
DO NOT USE THIS LINE						
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00	
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/27/2014 12:14 pm		
		1.00	2.00			
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	158014	140.00		
		1.00	2.00	3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141.00	Name: FRANCISCAN ALLIANCE, INC. AND AFFILI	Contractor's Name: WISCONSIN PHYSICIAN S SERVICE		Contractor's Number: 08101		141.00
142.00	Street: 1515 W DRAGON TRL	P0 Box: 1290	142.00			
143.00	City: MISHAWAKA	State: IN	Zip Code: 46544	143.00		
		1.00				
144.00	Are provider based physicians' costs included in Worksheet A?	Y		144.00		
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N		145.00		
		1.00		2.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00		
		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
161.10	CORF		N	N	N	161.10
		1.00				
Multi campus						
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N		165.00		
		Name	County	State	Zip Code	CBSA
		0	1.00	2.00	3.00	4.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5					0.00
		1.00				
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act						
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y		167.00		
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0		168.00		
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.50		169.00		
		Beginning	Ending			
		1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2012	09/30/2013	170.00		

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/27/2014 12:14 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	Y			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
Description		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/08/2014	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 150057

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

Worksheet S-2
Part II
Date/Time Prepared:
5/27/2014 12:14 pm

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			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
Interest Expense					
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
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			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.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			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
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			Y	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			Y	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BKD		BKD	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	502-581-0435		LV COSTREPORTS@BKD.COM	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	04/08/2014	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BKD	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150057

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

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2014 12:14 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Trips	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	91	33,666	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)		91	33,666	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT	34.00	8	2,920	0.00	0	11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		99	36,586	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		99				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: 150057

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

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2014 12:14 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	4,623	310	9,465			1.00
2.00 HMO and other (see instructions)	1,307	831				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	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	4,623	310	9,465			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	653	36	1,069			11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		19	566			13.00
14.00 Total (see instructions)	5,276	365	11,100	0.46	357.71	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.46	357.71	27.00
28.00 Observation Bed Days		57	562			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	67	100			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: 150057

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

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2014 12:14 pm

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	1,569	129	3,420	1.00
2.00 HMO and other (see instructions)			376			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	1,569	129	3,420	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00					25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 150057		Period: From 01/01/2013 To 12/31/2013		Worksheet S-3 Part II Date/Time Prepared: 5/27/2014 12:14 pm	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	20,977,415	0	20,977,415	744,029.98	28.19	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		556,234	0	556,234	20,501.03	27.13	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor (see instructions)		386,520	0	386,520	11,748.21	32.90	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract Labor: Physician-Part A - Administrative		45,508	0	45,508	215.88	210.80	13.00
14.00	Home office salaries & wage-related costs		7,436,149	0	7,436,149	169,476.30	43.88	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		6,792,227	0	6,792,227			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		184,894	0	184,894			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
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	1,612,269	0	1,612,269	68,257.16	23.62	27.00
28.00	Administrative & General under contract (see inst.)		319,518	0	319,518	3,306.68	96.63	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,208,666	0	1,208,666	52,591.40	22.98	30.00
31.00	Laundry & Linen Service	8.00	25,664	0	25,664	2,540.98	10.10	31.00
32.00	Housekeeping	9.00	883,845	0	883,845	67,575.22	13.08	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	448,955	-291,003	157,952	10,489.03	15.06	34.00
35.00	Dietary under contract (see instructions)		5,043	0	5,043	216.00	23.35	35.00
36.00	Cafeteria	11.00	0	291,003	291,003	18,821.00	15.46	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	75,769	0	75,769	2,010.22	37.69	38.00
39.00	Central Services and Supply	14.00	65,098	0	65,098	4,281.32	15.21	39.00
40.00	Pharmacy	15.00	783,923	0	783,923	20,604.24	38.05	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150057

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

Worksheet S-3
Part II
Date/Time Prepared:
5/27/2014 12:14 pm

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

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150057

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

Worksheet S-3
Part III
Date/Time Prepared:
5/27/2014 12:14 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	21,301,976	0	21,301,976	747,552.66	28.50	1.00
2.00	Excluded area salaries (see instructions)	556,234	0	556,234	20,501.03	27.13	2.00
3.00	Subtotal salaries (line 1 minus line 2)	20,745,742	0	20,745,742	727,051.63	28.53	3.00
4.00	Subtotal other wages & related costs (see inst.)	7,868,177	0	7,868,177	181,440.39	43.37	4.00
5.00	Subtotal wage-related costs (see inst.)	6,792,227	0	6,792,227	0.00	32.74	5.00
6.00	Total (sum of lines 3 thru 5)	35,406,146	0	35,406,146	908,492.02	38.97	6.00
7.00	Total overhead cost (see instructions)	5,428,750	0	5,428,750	250,693.25	21.65	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet S-3 Part IV Date/Time Prepared: 5/27/2014 12:14 pm
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		162,962	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		1,738,027	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		3,034,097	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		128,239	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		58,884	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		163,906	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		1,589,938	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		18,917	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		82,151	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		6,977,121	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150057

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

Worksheet S-3
Part V
Date/Time Prepared:
5/27/2014 12:14 pm

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet S-10 Date/Time Prepared: 5/27/2014 12:14 pm
---	--	----------------------	---	---

				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.246846		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		6,610,237		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0		5.00
6.00	Medicaid charges		37,688,065		6.00
7.00	Medicaid cost (line 1 times line 6)		9,303,148		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)		2,692,911		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)		2,692,911		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	15,525,153	0	15,525,153	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	3,832,322	0	3,832,322	21.00
22.00	Partial payment by patients approved for charity care	170,777	0	170,777	22.00
23.00	Cost of charity care (line 21 minus line 22)	3,661,545	0	3,661,545	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		4,227,580		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		128,063		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		4,099,517		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,011,949		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		4,673,494		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		7,366,405		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 150057		Period: From 01/01/2013 To 12/31/2013		Worksheet A	
Date/Time Prepared: 5/27/2014 12:14 pm							
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	0	5,313,467	5,313,467	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		4,550,253	-2,377,458	2,172,795	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	6,928,760	6,928,760	4.00
5.01	00510	ADMITTING	711,637	260,438	972,075	-245,062	5.01
5.02	00511	PATIENT ACCOUNTING	0	0	0	0	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	900,632	2,614,025	3,514,657	-264,281	5.03
7.00	00700	OPERATION OF PLANT	1,208,666	2,026,240	3,234,906	-401,980	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	25,664	181,477	207,141	-9,235	8.00
9.00	00900	HOUSEKEEPING	883,845	480,307	1,364,152	-304,934	9.00
10.00	01000	DIETARY	448,955	439,877	888,832	-813,061	10.00
11.00	01100	CAFETERIA	0	0	0	659,158	11.00
13.00	01300	NURSING ADMINISTRATION	75,769	27,953	103,722	-25,516	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	65,098	46,342	111,440	-42,774	14.00
15.00	01500	PHARMACY	783,923	2,690,512	3,474,435	-2,522,473	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1	1	-1	16.00
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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,590,112	2,997,216	7,587,328	-3,070,202	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,271,477	483,622	1,755,099	-448,846	34.00
43.00	04300	NURSERY	0	0	0	351,900	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,004,963	23,560,749	25,565,712	-17,104,259	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	393	393	998,667	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,361,313	1,170,687	2,532,000	-556,764	54.00
54.01	05401	ULTRA SOUND	206,536	81,442	287,978	-71,129	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	315,494	2,317,407	2,632,901	-105,952	55.00
60.00	06000	LABORATORY	0	2,614,670	2,614,670	-121,397	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	18,867	852,561	871,428	-658,415	64.00
65.00	06500	RESPIRATORY THERAPY	784,170	445,821	1,229,991	-414,093	65.00
66.00	06600	PHYSICAL THERAPY	1,317,618	494,062	1,811,680	-462,894	66.00
67.00	06700	OCCUPATIONAL THERAPY	132,365	57,967	190,332	-54,216	67.00
68.00	06800	SPEECH PATHOLOGY	324	104	428	-104	68.00
69.00	06900	ELECTROCARDIOLOGY	59,310	331,892	391,202	-70,148	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	122,805	73,658	196,463	-67,013	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,738,890	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	12,676,507	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,573,782	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	407,937	194,096	602,033	-128,881	90.00
90.01	09001	WOUND CARE INSTITUTE	20,721	9,578	30,299	-9,524	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	20,419	6,807	27,226	-6,807	90.02
90.03	09003	BARIATRIC MEDICINE	0	0	0	0	90.03
90.04	04950	MARKETING & PLANNING	0	0	0	0	90.04
91.00	09100	EMERGENCY	2,682,561	1,258,998	3,941,559	-1,052,270	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		2,645,610	2,645,610	-2,645,610	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,421,181	52,914,765	73,335,946	185,832	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	45,140	88,325	133,465	-15,217	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	98,695	167,620	266,315	-32,797	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	145,578	86,818	232,396	-49,124	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THER	266,821	523,355	790,176	-88,694	194.01
194.02	07952	JV MV ENDOSCOPY	0	3,303,608	3,303,608	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118-199)	20,977,415	57,084,491	78,061,906	0	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150057

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

Worksheet A
Date/Time Prepared:
5/27/2014 12:14 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-2,395,234	2,918,233	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	2,172,795	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	188,222	7,116,982	4.00
5.01	00510	ADMINISTRATIVE	546,563	1,273,576	5.01
5.02	00511	PATIENT ACCOUNTING	1,289,908	1,289,908	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	11,067,616	14,317,992	5.03
7.00	00700	OPERATION OF PLANT	-3,600	2,829,326	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-17,037	180,869	8.00
9.00	00900	HOUSEKEEPING	-21,000	1,038,218	9.00
10.00	01000	DIETARY	-299,931	-224,160	10.00
11.00	01100	CAFETERIA	0	659,158	11.00
13.00	01300	NURSING ADMINISTRATION	0	78,206	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-9	68,657	14.00
15.00	01500	PHARMACY	-80,243	871,719	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	254,312	254,312	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	33,991	33,991	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	34,404	34,404	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-26,344	4,490,782	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	-401,675	904,578	34.00
43.00	04300	NURSERY	0	351,900	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-2,106,845	6,354,608	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	999,060	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-24,853	1,950,383	54.00
54.01	05401	ULTRA SOUND	0	216,849	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	-727,717	1,799,232	55.00
60.00	06000	LABORATORY	-1,682,104	811,169	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	213,013	64.00
65.00	06500	RESPIRATORY THERAPY	-19,405	796,493	65.00
66.00	06600	PHYSICAL THERAPY	-11,509	1,337,277	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	136,116	67.00
68.00	06800	SPEECH PATHOLOGY	0	324	68.00
69.00	06900	ELECTROCARDIOLOGY	0	321,054	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	129,450	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,738,890	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	12,676,507	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,573,782	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	473,152	90.00
90.01	09001	WOUND CARE INSTITUTE	0	20,775	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	20,419	90.02
90.03	09003	BARITRIC MEDICINE	0	0	90.03
90.04	04950	MARKETING & PLANNING	0	0	90.04
91.00	09100	EMERGENCY	-1,341	2,887,948	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,596,169	79,117,947	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	118,248	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	233,518	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	1,203,132	1,386,404	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THER	0	701,482	194.01
194.02	07952	JV MV ENDOSCOPY	0	3,303,608	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	193,607	193,607	194.03
200.00		TOTAL (SUM OF LINES 118-199)	6,992,908	85,054,814	200.00

RECLASSIFICATIONS

Provider CCN: 150057

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

Worksheet A-6
Date/Time Prepared:
5/27/2014 12:14 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - MEDICAL SUPPLIES RECLASS					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	26	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	4,738,890	2.00
3.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	12,676,507	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
TOTALS			0	17,415,423	
B - DRUG RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,573,782	1.00
2.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	1	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	2,573,783	
C - EQUIPMENT LEASE RECLASS					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	190,206	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
TOTALS			0	190,206	
D - DEPRECIATION RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	2,667,857	1.00
2.00		0.00	0	0	2.00
TOTALS			0	2,667,857	
E - INTEREST RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	2,645,610	1.00
TOTALS			0	2,645,610	
F - EMPLOYEE BENEFITS RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6,928,760	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
	TOTALS		0	6,928,760		
	G - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	291,003	368,155		1.00
	TOTALS		291,003	368,155		
	H - NURSERY RECLASS					
1.00	NURSERY	43.00	340,712	11,188		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	967,260	31,762		2.00
	TOTALS		1,307,972	42,950		
500.00	Grand Total: Increases		1,598,975	32,832,744		500.00

RECLASSIFICATIONS

Provider CCN: 150057

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

Worksheet A-6
Date/Time Prepared:
5/27/2014 12:14 pm

Decreases							
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
6.00	7.00	8.00	9.00	10.00			
A - MEDICAL SUPPLIES RECLASS							
1.00	ADM ITTING	5.01	0	7,007	0	1.00	
2.00	OPERATION OF PLANT	7.00	0	142	0	2.00	
3.00	LAUNDRY & LINEN SERVICE	8.00	0	657	0	3.00	
4.00	HOUSEKEEPING	9.00	0	10,447	0	4.00	
5.00	DIETARY	10.00	0	4,317	0	5.00	
6.00	NURSING ADMINISTRATION	13.00	0	172	0	6.00	
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	20,946	0	7.00	
8.00	PHARMACY	15.00	0	184,741	0	8.00	
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	1	0	9.00	
10.00	ADULTS & PEDIATRICS	30.00	0	184,897	0	10.00	
11.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	24,185	0	11.00	
12.00	OPERATING ROOM	50.00	0	16,392,436	0	12.00	
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	355	0	13.00	
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	101,533	0	14.00	
15.00	ULTRA SOUND	54.01	0	2,007	0	15.00	
16.00	RADIOLOGY-THERAPEUTIC	55.00	0	797	0	16.00	
17.00	LABORATORY	60.00	0	21,182	0	17.00	
18.00	INTRAVENOUS THERAPY	64.00	0	55,911	0	18.00	
19.00	RESPIRATORY THERAPY	65.00	0	110,810	0	19.00	
20.00	PHYSICAL THERAPY	66.00	0	22,813	0	20.00	
21.00	OCCUPATIONAL THERAPY	67.00	0	9,822	0	21.00	
22.00	ELECTROCARDIOLOGY	69.00	0	50,322	0	22.00	
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	24,652	0	23.00	
24.00	CLINIC	90.00	0	26,216	0	24.00	
25.00	WOUND CARE INSTITUTE	90.01	0	2,591	0	25.00	
26.00	EMERGENCY	91.00	0	156,464	0	26.00	
	TOTALS		0	17,415,423			
B - DRUG RECLASS							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	149	0	1.00	
2.00	PHARMACY	15.00	0	1,934,039	0	2.00	
3.00	ADULTS & PEDIATRICS	30.00	0	199	0	3.00	
4.00	OPERATING ROOM	50.00	0	41,249	0	4.00	
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	259	0	5.00	
6.00	RADIOLOGY-THERAPEUTIC	55.00	0	175	0	6.00	
7.00	LABORATORY	60.00	0	22	0	7.00	
8.00	INTRAVENOUS THERAPY	64.00	0	595,946	0	8.00	
9.00	RESPIRATORY THERAPY	65.00	0	244	0	9.00	
10.00	PHYSICAL THERAPY	66.00	0	684	0	10.00	
11.00	OCCUPATIONAL THERAPY	67.00	0	95	0	11.00	
12.00	ELECTROCARDIOLOGY	69.00	0	84	0	12.00	
13.00	ELECTROENCEPHALOGRAPHY	70.00	0	28	0	13.00	
14.00	CLINIC	90.00	0	32	0	14.00	
15.00	EMERGENCY	91.00	0	578	0	15.00	
	TOTALS		0	2,573,783			
C - EQUIPMENT LEASE RECLASS							
1.00	DIETARY	10.00	0	1,144	10	1.00	
2.00	PHARMACY	15.00	0	144,588	0	2.00	
3.00	ADULTS & PEDIATRICS	30.00	0	296	0	3.00	
4.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	30	0	4.00	
5.00	OPERATING ROOM	50.00	0	1,000	0	5.00	
6.00	INTRAVENOUS THERAPY	64.00	0	247	0	6.00	
7.00	RESPIRATORY THERAPY	65.00	0	41,685	0	7.00	
8.00	ELECTROENCEPHALOGRAPHY	70.00	0	1,216	0	8.00	
	TOTALS		0	190,206			
D - DEPRECIATION RECLASS							
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2,567,664	9	1.00	
2.00	LABORATORY	60.00	0	100,193	0	2.00	
	TOTALS		0	2,667,857			
E - INTEREST RECLASS							
1.00	INTEREST EXPENSE	113.00	0	2,645,610	11	1.00	
	TOTALS		0	2,645,610			
F - EMPLOYEE BENEFITS RECLASS							
1.00	ADM ITTING	5.01	0	238,055	0	1.00	
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	264,307	0	2.00	
3.00	OPERATION OF PLANT	7.00	0	401,838	0	3.00	
4.00	LAUNDRY & LINEN SERVICE	8.00	0	8,578	0	4.00	
5.00	HOUSEKEEPING	9.00	0	294,487	0	5.00	
6.00	DIETARY	10.00	0	148,442	0	6.00	
7.00	NURSING ADMINISTRATION	13.00	0	25,344	0	7.00	
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	21,679	0	8.00	
9.00	PHARMACY	15.00	0	259,105	0	9.00	

RECLASSIFICATIONS

Provider CCN: 150057

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

Worksheet A-6

Date/Time Prepared:
5/27/2014 12:14 pm

Decreases							
Cost Center	Line #	Salary	Other	Wkst.	A-7 Ref.		
6.00	7.00	8.00	9.00	10.00			
10.00	ADULTS & PEDIATRICS	30.00	0	1,533,888	0		10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	424,632	0		11.00
12.00	OPERATING ROOM	50.00	0	669,574	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	454,972	0		13.00
14.00	ULTRA SOUND	54.01	0	69,122	0		14.00
15.00	RADIOLOGY-THERAPEUTIC	55.00	0	104,980	0		15.00
16.00	INTRAVENOUS THERAPY	64.00	0	6,311	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	261,354	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	439,397	0		18.00
19.00	OCCUPATIONAL THERAPY	67.00	0	44,299	0		19.00
20.00	SPEECH PATHOLOGY	68.00	0	104	0		20.00
21.00	ELECTROCARDIOLOGY	69.00	0	19,742	0		21.00
22.00	ELECTROENCEPHALOGRAPHY	70.00	0	41,117	0		22.00
23.00	CLINIC	90.00	0	102,633	0		23.00
24.00	WOUND CARE INSTITUTE	90.01	0	6,933	0		24.00
25.00	OP NUTRITIONAL COUNSELING	90.02	0	6,807	0		25.00
26.00	EMERGENCY	91.00	0	895,228	0		26.00
27.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	15,217	0		27.00
28.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	32,797	0		28.00
29.00	COMMUNITY RELATIONS & MARKETING	194.00	0	49,124	0		29.00
30.00	PLAINFIELD RADIOLOGY & PHYSICAL THER	194.01	0	88,694	0		30.00
	TOTALS		0	6,928,760			
G - CAFETERIA RECLASS							
1.00	DIETARY	10.00	291,003	368,155	0		1.00
	TOTALS		291,003	368,155			
H - NURSERY RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	1,307,972	42,950	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		1,307,972	42,950			
500.00	Grand Total: Decreases		1,598,975	32,832,744			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150057

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

Worksheet A-7
Part I
Date/Time Prepared:
5/27/2014 12:14 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	1,418,904	13,815	0	13,815	2.00
3.00	Buildings and Fixtures	55,378,833	588,615	0	588,615	3.00
4.00	Building Improvements	592,542	731,232	0	731,232	4.00
5.00	Fixed Equipment	24,629,476	378,064	0	378,064	5.00
6.00	Movable Equipment	24,294,608	0	0	0	1,641,783
7.00	HIT designated Assets	0	0	0	0	0
8.00	Subtotal (sum of lines 1-7)	106,314,363	1,711,726	0	1,711,726	1,641,783
9.00	Reconciling Items	0	0	0	0	0
10.00	Total (line 8 minus line 9)	106,314,363	1,711,726	0	1,711,726	1,641,783
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0			1.00
2.00	Land Improvements	1,432,719	35,316			2.00
3.00	Buildings and Fixtures	55,967,448	421,642			3.00
4.00	Building Improvements	1,323,774	386,663			4.00
5.00	Fixed Equipment	25,007,540	13,130			5.00
6.00	Movable Equipment	22,652,825	12,795,658			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	106,384,306	13,652,409			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	106,384,306	13,652,409			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150057

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

Worksheet A-7
Part II
Date/Time Prepared:
5/27/2014 12:14 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4,550,253	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,550,253	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	NEW CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	4,550,253				2.00
3.00	Total (sum of lines 1-2)	0	4,550,253				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150057

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

Worksheet A-7
Part III
Date/Time Prepared:
5/27/2014 12:14 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	83,731,481	0	83,731,481	0.787066	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	22,652,825	0	22,652,825	0.212934	0	2.00
3.00	Total (sum of lines 1-2)	106,384,306	0	106,384,306	1.000000	0	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,667,857	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,982,589	190,206	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,650,446	190,206	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	250,376	0	0	0	2,918,233	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,172,795	2.00
3.00	Total (sum of lines 1-2)	250,376	0	0	0	5,091,028	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150057

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

Worksheet A-8

Date/Time Prepared:
5/27/2014 12:14 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	B	-140,233	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-3,336,682			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	13,116,686			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-251,041	DIETARY	10.00	0	14.00
15.00 Rental of quarters to employee and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts		0		0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines	B	-9,692	DIETARY	10.00	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		ORESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			ONEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0	0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			OADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

Provider CCN: 150057

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

Worksheet A-8

Date/Time Prepared:
 5/27/2014 12:14 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
33.00 MISC REVENUE - A&P	B	-26,193	ADULTS & PEDIATRICS	30.00	0 33.00
34.00 MISC REVENUE - OR	B	-937,321	OPERATING ROOM	50.00	0 34.00
35.00 MISC REVENUE - CENTRAL SUPPLY	B	-9	CENTRAL SERVICES & SUPPLY	14.00	0 35.00
36.00 MISC REVENUE - RESP THERAPY	B	-3,930	RESPIRATORY THERAPY	65.00	0 36.00
37.00 MISC REVENUE - RADIOLOGY	B	-6,554	RADIOLOGY-DIAGNOSTIC	54.00	0 37.00
38.00 MISC REVENUE - PHARMACY	B	-156,474	PHARMACY	15.00	0 38.00
39.00 MISC REVENUE - PT	B	-11,509	PHYSICAL THERAPY	66.00	0 39.00
40.00 MISC REVENUE - DIETARY	B	-39,198	DIETARY	10.00	0 40.00
41.00 MISC REVENUE - ENGINEERING	B	-3,600	OPERATION OF PLANT	7.00	0 41.00
42.00 MISC REVENUE - ENVIRONMENTAL SVCS	B	-21,000	HOUSEKEEPING	9.00	0 42.00
43.00 MISC REVENUE - LINEN	B	-17,037	LAUNDRY & LINEN SERVICE	8.00	0 43.00
44.00 MISC REVENUE - RADIATION THERAPY	B	-727,717	RADIOLOGY-THERAPEUTIC	55.00	0 44.00
45.00 MISC REVENUE - A&G	B	-14,260	OTHER ADMINISTRATIVE AND GENERAL	5.03	0 45.00
46.00 ADMIN - DONATIONS EXPENSE	A	-3,408	OTHER ADMINISTRATIVE AND GENERAL	5.03	0 46.00
47.00 RECRUITMENT	A	-100	ADULTS & PEDIATRICS	30.00	0 47.00
48.00 NONALLOWABLE INTEREST	A	-417,820	NEW CAP REL COSTS-BLDG & FIXT	1.00	11 48.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		6,992,908			50.00

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

Provider CCN: 150057

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

Worksheet A-8-1

Date/Time Prepared:
5/27/2014 12:14 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED SERVICE ALLOCATION	188,222	0
2.00	5.01	ADMITTING	SHARED SERVICE ALLOCATION	546,563	0
3.00	5.02	PATIENT ACCOUNTING	SHARED SERVICE ALLOCATION	1,289,908	0
4.00	5.03	OTHER ADMINISTRATIVE AND GEN	SHARED SERVICE ALLOCATION	4,453,448	0
4.01	16.00	MEDICAL RECORDS & LIBRARY	SHARED SERVICE ALLOCATION	254,312	0
4.02	194.00	COMMUNITY RELATIONS & MARKET	SHARED SERVICE ALLOCATION	1,203,132	0
4.03	194.03	SOUTHWEST CENTER FOR WOMENS	SHARED SERVICE ALLOCATION	193,607	0
4.04	5.03	OTHER ADMINISTRATIVE AND GEN	FRANCISCAN HOME OFFICE	867,802	0
4.06	1.00	NEW CAP REL COSTS-BLDG & FIX	FRANCISCAN HOME OFFICE	668,196	2,645,610
4.07	5.03	OTHER ADMINISTRATIVE AND GEN	FRANCISCAN HOME OFFICE	5,937,361	0
4.08	15.00	PHARMACY	FRANCISCAN HOME OFFICE	190,518	105,314
4.09	21.00	I&R SERVICES-SALARY & FRINGE	INTERNS & RESIDENTS	33,991	0
4.10	22.00	I&R SERVICES-OTHER PRGM COST	INTERNS & RESIDENTS	34,404	0
4.11	60.00	LABORATORY	APHL LAB	2,253,970	2,247,824
5.00	0			18,115,434	4,998,748

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

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

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

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

6.00	A	HOME OFFICE	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: 150057

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

Worksheet A-8-1

Date/Time Prepared:
5/27/2014 12:14 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	188,222	0		1.00
2.00	546,563	0		2.00
3.00	1,289,908	0		3.00
4.00	4,453,448	0		4.00
4.01	254,312	0		4.01
4.02	1,203,132	0		4.02
4.03	193,607	0		4.03
4.04	867,802	0		4.04
4.06	-1,977,414	11		4.06
4.07	5,937,361	0		4.07
4.08	85,204	0		4.08
4.09	33,991	0		4.09
4.10	34,404	0		4.10
4.11	6,146	0		4.11
5.00	13,116,686			5.00

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

Related Organization(s) and/or Home Office	Type of Business		
	6.00		

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00			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: 150057

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

Worksheet A-8-2

Date/Time Prepared:
5/27/2014 12:14 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.03	OTHER ADMINISTRATIVE AND GENERAL	33,094	33,094	0	0	0	1.00
2.00	15.00	PHARMACY	16,108	0	16,108	138,700	107	2.00
3.00	30.00	ADULTS & PEDIATRICS	51	51	0	0	0	3.00
4.00	34.00	SURGICAL INTENSIVE CARE UNIT	403,675	399,250	4,425	138,700	30	4.00
5.00	50.00	OPERATING ROOM	1,169,524	1,169,524	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	22,500	0	22,500	138,700	63	6.00
7.00	60.00	LABORATORY	1,688,250	1,688,250	0	0	0	7.00
8.00	65.00	RESPIRATORY THERAPY	15,475	15,475	0	0	0	8.00
9.00	91.00	EMERGENCY	2,475	0	2,475	138,700	17	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,351,152	3,305,644	45,508		217	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.03	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	1.00
2.00	15.00	PHARMACY	7,135	357	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	34.00	SURGICAL INTENSIVE CARE UNIT	2,000	100	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	4,201	210	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	1,134	57	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			14,470	724	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.03	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	33,094		1.00
2.00	15.00	PHARMACY	0	7,135	8,973	8,973		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	51		3.00
4.00	34.00	SURGICAL INTENSIVE CARE UNIT	0	2,000	2,425	401,675		4.00
5.00	50.00	OPERATING ROOM	0	0	0	1,169,524		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	4,201	18,299	18,299		6.00
7.00	60.00	LABORATORY	0	0	0	1,688,250		7.00
8.00	65.00	RESPIRATORY THERAPY	0	0	0	15,475		8.00
9.00	91.00	EMERGENCY	0	1,134	1,341	1,341		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	14,470	31,038	3,336,682		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150057

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

Worksheet B
Part I
Date/Time Prepared:
5/27/2014 12:14 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING		
		NEW BLDG & FIXT	NEW MVBLE EQUIP				
	0	1.00	2.00	4.00	5.01		
GENERAL SERVICE COST CENTERS							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	2,918,233	2,918,233				1.00	
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	2,172,795		2,172,795			2.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	7,116,982	10,159	7,564	7,134,705		4.00	
5.01 00510 ADMITTING	1,273,576	34,273	25,518	242,038	1,575,405	5.01	
5.02 00511 PATIENT ACCOUNTING	1,289,908	0	0	0	0	5.02	
5.03 00560 OTHER ADMINISTRATIVE AND GENERAL	14,317,992	79,281	59,029	306,318	0	5.03	
7.00 00700 OPERATION OF PLANT	2,829,326	98,559	73,383	411,084	0	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	180,869	4,710	3,507	8,729	0	8.00	
9.00 00900 HOUSEKEEPING	1,038,218	19,805	14,746	300,608	0	9.00	
10.00 01000 DIETARY	-224,160	74,633	55,569	53,722	0	10.00	
11.00 01100 CAFETERIA	659,158	0	0	98,974	0	11.00	
13.00 01300 NURSING ADMINISTRATION	78,206	0	0	25,770	0	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	68,657	0	0	22,141	0	14.00	
15.00 01500 PHARMACY	871,719	0	0	266,623	0	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	254,312	24,502	18,243	0	0	16.00	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	33,991	0	0	0	0	21.00	
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	34,404	0	0	0	0	22.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	4,490,782	693,295	516,198	1,116,291	159,968	30.00	
34.00 03400 SURGICAL INTENSIVE CARE UNIT	904,578	67,832	50,505	432,447	27,028	34.00	
43.00 04300 NURSERY	351,900	0	0	115,881	10,837	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	6,354,608	414,104	308,325	681,916	270,794	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	999,060	0	0	328,979	30,604	52.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,950,383	139,910	104,171	463,002	36,068	54.00	
54.01 05401 ULTRA SOUND	216,849	4,259	3,171	70,246	3,184	54.01	
55.00 05500 RADIOLOGY-THERAPEUTIC	1,799,232	106,977	79,651	107,304	1,360	55.00	
60.00 06000 LABORATORY	811,169	50,908	37,904	0	88,684	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01	
64.00 06400 INTRAVENOUS THERAPY	213,013	0	0	6,417	3,259	64.00	
65.00 06500 RESPIRATORY THERAPY	796,493	16,974	12,638	266,707	32,982	65.00	
66.00 06600 PHYSICAL THERAPY	1,337,277	65,589	48,835	448,140	46,362	66.00	
67.00 06700 OCCUPATIONAL THERAPY	136,116	0	0	45,019	4,483	67.00	
68.00 06800 SPEECH PATHOLOGY	324	0	0	110	1,204	68.00	
69.00 06900 ELECTROCARDIOLOGY	321,054	33,684	25,080	20,172	5,467	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	129,450	45,497	33,875	41,768	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,738,890	15,333	11,416	0	238,186	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	12,676,507	0	0	0	425,919	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	2,573,782	32,218	23,988	0	131,453	73.00	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	473,152	0	0	138,745	70	90.00	
90.01 09001 WOUND CARE INSTITUTE	20,775	0	0	7,048	47	90.01	
90.02 09002 OP NUTRITIONAL COUNSELING	20,419	0	0	6,945	0	90.02	
90.03 09003 BARIATRIC MEDICINE	0	0	0	0	0	90.03	
90.04 04950 MARKETING & PLANNING	0	0	0	0	0	90.04	
91.00 09100 EMERGENCY	2,887,948	184,066	137,048	912,377	57,446	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
OTHER REIMBURSABLE COST CENTERS							
99.10 09910 CORF	0	0	0	0	0	99.10	
SPECIAL PURPOSE COST CENTERS							
113.00 11300 INTEREST EXPENSE						113.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	79,117,947	2,216,568	1,650,364	6,945,521	1,575,405	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	118,248	0	0	15,353	0	190.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	233,518	639,195	475,918	33,568	0	192.00	
194.00 07950 COMMUNITY RELATIONS & MARKETING	1,386,404	0	0	49,513	0	194.00	
194.01 07951 PLAINFIELD RADIOLOGY & PHYSICAL THER	701,482	0	0	90,750	0	194.01	
194.02 07952 JV MV ENDOSCOPY	3,303,608	62,470	46,513	0	0	194.02	
194.03 07953 SOUTHWEST CENTER FOR WOMENS HEALTH	193,607	0	0	0	0	194.03	
200.00	Cross Foot Adjustments					200.00	
201.00	Negative Cost Centers					201.00	
202.00	TOTAL (sum lines 118-201)	85,054,814	2,918,233	2,172,795	7,134,705	1,575,405	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150057

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

Worksheet B
Part I
Date/Time Prepared:
5/27/2014 12:14 pm

Cost Center Description		PATIENT ACCOUNTING	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5.02	5A.02	5.03	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00511	1,289,908					5.02
5.03	00560	0	14,762,620	14,762,620			5.03
7.00	00700	0	3,412,352	716,246	4,128,598		7.00
8.00	00800	0	197,815	41,521	7,213	246,549	8.00
9.00	00900	0	1,373,377	288,269	30,329	0	9.00
10.00	01000	0	-40,236	0	114,294	0	10.00
11.00	01100	0	758,132	159,130	0	0	11.00
13.00	01300	0	103,976	21,824	0	0	13.00
14.00	01400	0	90,798	19,058	0	0	14.00
15.00	01500	0	1,138,342	238,936	0	0	15.00
16.00	01600	0	297,057	62,352	37,522	0	16.00
21.00	02100	0	33,991	7,135	0	0	21.00
22.00	02200	0	34,404	7,221	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	58,037	7,034,571	1,476,542	1,061,715	46,438	30.00
34.00	03400	9,315	1,491,705	313,106	103,877	45,936	34.00
43.00	04300	3,735	482,353	101,245	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	130,756	8,160,503	1,712,873	634,160	55,396	50.00
52.00	05200	10,599	1,369,242	287,401	0	0	52.00
54.00	05400	181,207	2,874,741	603,402	214,258	23,404	54.00
54.01	05401	17,390	315,099	66,139	6,522	0	54.01
55.00	05500	33,766	2,128,290	446,724	163,825	3,889	55.00
60.00	06000	117,144	1,105,809	232,107	77,961	0	60.00
60.01	06001	0	0	0	0	0	60.01
64.00	06400	7,737	230,426	48,366	0	0	64.00
65.00	06500	16,084	1,141,878	239,678	25,993	0	65.00
66.00	06600	42,540	1,988,743	417,433	100,443	6,580	66.00
67.00	06700	3,708	189,326	39,739	0	491	67.00
68.00	06800	417	2,055	431	0	0	68.00
69.00	06900	27,088	432,545	90,790	51,584	0	69.00
70.00	07000	9,930	260,520	54,683	69,674	1,515	70.00
71.00	07100	105,091	5,108,916	1,072,351	23,480	0	71.00
72.00	07200	150,740	13,253,166	2,781,798	0	0	72.00
73.00	07300	105,524	2,866,965	601,770	49,339	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	10,305	622,272	130,614	0	965	90.00
90.01	09001	1,007	28,877	6,061	0	96	90.01
90.02	09002	240	27,604	5,794	0	0	90.02
90.03	09003	0	0	0	0	0	90.03
90.04	04950	0	0	0	0	0	90.04
91.00	09100	247,548	4,426,433	929,099	281,879	46,824	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		1,289,908	77,704,667	13,219,838	3,054,068	231,534	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	133,601	28,043	0	0	190.00
192.00	19200	0	1,382,199	290,121	978,863	351	192.00
194.00	07950	0	1,435,917	301,396	0	0	194.00
194.01	07951	0	792,232	166,288	0	0	194.01
194.02	07952	0	3,412,591	716,296	95,667	14,664	194.02
194.03	07953	0	193,607	40,638	0	0	194.03
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		1,289,908	85,054,814	14,762,620	4,128,598	246,549	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150057		Period: From 01/01/2013 To 12/31/2013		Worksheet B Part I Date/Time Prepared: 5/27/2014 12:14 pm	
Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	ADMITTING					5.01
5.02	00511	PATIENT ACCOUNTING					5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL					5.03
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING	1,691,975				9.00
10.00	01000	DIETARY	47,269	121,327			10.00
11.00	01100	CAFETERIA	0	0	917,262		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	3,520	129,320	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	7,497	0	14.00
15.00	01500	PHARMACY	0	0	36,084	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,518	0	0	0	16.00
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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	439,105	103,455	178,662	41,376	132
34.00	03400	SURGICAL INTENSIVE CARE UNIT	42,961	11,685	53,161	12,311	18
43.00	04300	NURSERY	0	6,187	15,624	3,618	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	262,275	0	130,109	30,131	258
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	44,356	10,272	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	88,612	0	89,897	0	105
54.01	05401	ULTRA SOUND	2,697	0	9,068	0	1
55.00	05500	RADIOLOGY-THERAPEUTIC	67,755	0	16,844	0	3
60.00	06000	LABORATORY	32,243	0	0	0	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	932	0	7
65.00	06500	RESPIRATORY THERAPY	10,750	0	42,653	0	22
66.00	06600	PHYSICAL THERAPY	41,541	0	79,515	0	48
67.00	06700	OCCUPATIONAL THERAPY	0	0	9,156	0	8
68.00	06800	SPEECH PATHOLOGY	0	0	16	0	0
69.00	06900	ELECTROCARDIOLOGY	21,334	0	2,254	0	14
70.00	07000	ELECTROENCEPHALOGRAPHY	28,816	0	5,793	0	11
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,711	0	0	0	31,731
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	84,711
73.00	07300	DRUGS CHARGED TO PATIENTS	20,406	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	17,315	0	11
90.01	09001	WOUND CARE INSTITUTE	0	0	1,147	0	0
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	1,252	0	0
90.03	09003	BIATRIC MEDICINE	0	0	0	0	0
90.04	04950	MARKETING & PLANNING	0	0	0	0	0
91.00	09100	EMERGENCY	116,579	0	136,502	31,612	158
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,247,572	121,327	881,357	129,320	117,323
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	7,557	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	404,837	0	6,639	0	15
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	7,562	0	3
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THER	0	0	14,147	0	10
194.02	07952	JV MV ENDOSCOPY	39,566	0	0	0	2
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,691,975	121,327	917,262	129,320	117,353

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150057

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

Worksheet B
Part I
Date/Time Prepared:
5/27/2014 12:14 pm

Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	INTERNS & RESIDENTS		Subtotal	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
			15.00	16.00		
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 00510 ADMITTING						5.01
5.02 00511 PATIENT ACCOUNTING						5.02
5.03 00560 OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY	1,413,447					15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	412,449				16.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	41,126			21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	41,625		22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0	18,553	41,126	41,625	10,483,300	30.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	2,978	0	0	2,077,738	34.00
43.00 04300 NURSERY	0	1,194	0	0	610,221	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	41,800	0	0	11,027,505	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	3,388	0	0	1,714,659	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	57,929	0	0	3,952,348	54.00
54.01 05401 ULTRA SOUND	0	5,559	0	0	405,085	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	10,794	0	0	2,838,124	55.00
60.00 06000 LABORATORY	0	37,449	0	0	1,485,569	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 06400 INTRAVENOUS THERAPY	0	2,473	0	0	282,204	64.00
65.00 06500 RESPIRATORY THERAPY	0	5,142	0	0	1,466,116	65.00
66.00 06600 PHYSICAL THERAPY	0	13,599	0	0	2,647,902	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	1,185	0	0	239,905	67.00
68.00 06800 SPEECH PATHOLOGY	0	133	0	0	2,635	68.00
69.00 06900 ELECTROCARDIOLOGY	0	8,659	0	0	607,180	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	3,175	0	0	424,187	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	33,596	0	0	6,279,785	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	48,189	0	0	16,167,864	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,413,447	33,734	0	0	4,985,661	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	3,294	0	0	774,471	90.00
90.01 09001 WOUND CARE INSTITUTE	0	322	0	0	36,503	90.01
90.02 09002 OP NUTRITIONAL COUNSELING	0	77	0	0	34,727	90.02
90.03 09003 BARIATRIC MEDICINE	0	0	0	0	0	90.03
90.04 04950 MARKETING & PLANNING	0	0	0	0	0	90.04
91.00 09100 EMERGENCY	0	79,227	0	0	6,048,313	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1,413,447	412,449	41,126	41,625	74,592,002	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	169,201	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	3,063,025	192.00
194.00 07950 COMMUNITY RELATIONS & MARKETING	0	0	0	0	1,744,878	194.00
194.01 07951 PLAINFIELD RADIOLOGY & PHYSICAL THER	0	0	0	0	972,677	194.01
194.02 07952 JV MV ENDOSCOPY	0	0	0	0	4,278,786	194.02
194.03 07953 SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	234,245	194.03
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	1,413,447	412,449	41,126	41,625	85,054,814	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part I Date/Time Prepared: 5/27/2014 12:14 pm
---	--	----------------------	---	--

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00510	ADMITTING		5.01
5.02	00511	PATIENT ACCOUNTING		5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL		5.03
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-82,751	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	34.00
43.00	04300	NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
54.01	05401	ULTRA SOUND	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
60.00	06000	LABORATORY	0	60.00
60.01	06001	BLOOD LABORATORY	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	90.02
90.03	09003	BARIATRIC MEDICINE	0	90.03
90.04	04950	MARKETING & PLANNING	0	90.04
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	99.10
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-82,751	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THER	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	194.03
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118-201)	-82,751	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150057

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

Worksheet B
Part II
Date/Time Prepared:
5/27/2014 12:14 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	10,159	7,564	17,723	4.00
5.01 00510	ADMITTING	0	34,273	25,518	59,791	5.01
5.02 00511	PATIENT ACCOUNTING	0	0	0	0	5.02
5.03 00560	OTHER ADMINISTRATIVE AND GENERAL	867,802	79,281	59,029	1,006,112	5.03
7.00 00700	OPERATION OF PLANT	0	98,559	73,383	171,942	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	4,710	3,507	8,217	8.00
9.00 00900	HOUSEKEEPING	0	19,805	14,746	34,551	9.00
10.00 01000	DIETARY	0	74,633	55,569	130,202	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	24,502	18,243	42,745	16.00
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
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	693,295	516,198	1,209,493	30.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	67,832	50,505	118,337	34.00
43.00 04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	414,104	308,325	722,429	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	139,910	104,171	244,081	54.00
54.01 05401	ULTRA SOUND	0	4,259	3,171	7,430	54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	0	106,977	79,651	186,628	55.00
60.00 06000	LABORATORY	0	50,908	37,904	88,812	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	16,974	12,638	29,612	65.00
66.00 06600	PHYSICAL THERAPY	0	65,589	48,835	114,424	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	33,684	25,080	58,764	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	45,497	33,875	79,372	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	15,333	11,416	26,749	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	32,218	23,988	56,206	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 09001	WOUND CARE INSTITUTE	0	0	0	0	90.01
90.02 09002	OP NUTRITIONAL COUNSELING	0	0	0	0	90.02
90.03 09003	BARITRIC MEDICINE	0	0	0	0	90.03
90.04 04950	MARKETING & PLANNING	0	0	0	0	90.04
91.00 09100	EMERGENCY	0	184,066	137,048	321,114	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	867,802	2,216,568	1,650,364	4,734,734	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	639,195	475,918	1,115,113	192.00
194.00 07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	194.00
194.01 07951	PLAINFIELD RADIOLOGY & PHYSICAL THER	0	0	0	0	194.01
194.02 07952	JV MV ENDOSCOPY	0	62,470	46,513	108,983	194.02
194.03 07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	194.03
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	867,802	2,918,233	2,172,795	5,958,830	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150057		Period: From 01/01/2013 To 12/31/2013		Worksheet B Part II Date/Time Prepared: 5/27/2014 12:14 pm	
Cost Center Description		ADMINISTRATIVE	PATIENT ACCOUNTING	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5.01	5.02	5.03	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	ADMINISTRATIVE	60,392				5.01
5.02	00511	PATIENT ACCOUNTING	0	0			5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	0	0	1,006,873		5.03
7.00	00700	OPERATION OF PLANT	0	0	48,851	221,814	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	2,832	388	11,459
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	2,832	388	8.00
9.00	00900	HOUSEKEEPING	0	0	19,661	1,629	0
9.00	00900	HOUSEKEEPING	0	0	19,661	1,629	9.00
10.00	01000	DIETARY	0	0	0	6,141	0
10.00	01000	DIETARY	0	0	0	6,141	10.00
11.00	01100	CAFETERIA	0	0	10,853	0	0
11.00	01100	CAFETERIA	0	0	10,853	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,489	0	0
13.00	01300	NURSING ADMINISTRATION	0	0	1,489	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,300	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,300	0	14.00
15.00	01500	PHARMACY	0	0	16,297	0	0
15.00	01500	PHARMACY	0	0	16,297	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	4,253	2,016	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	4,253	2,016	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	487	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	487	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	493	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	493	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,129	0	100,707	57,041	2,158
30.00	03000	ADULTS & PEDIATRICS	6,129	0	100,707	57,041	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,036	0	21,355	5,581	2,135
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,036	0	21,355	5,581	34.00
43.00	04300	NURSERY	415	0	6,905	0	0
43.00	04300	NURSERY	415	0	6,905	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,375	0	116,826	34,071	2,575
50.00	05000	OPERATING ROOM	10,375	0	116,826	34,071	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,173	0	19,602	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,173	0	19,602	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,382	0	41,155	11,511	1,088
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,382	0	41,155	11,511	54.00
54.01	05401	ULTRA SOUND	122	0	4,511	350	0
54.01	05401	ULTRA SOUND	122	0	4,511	350	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	52	0	30,469	8,802	181
55.00	05500	RADIOLOGY-THERAPEUTIC	52	0	30,469	8,802	55.00
60.00	06000	LABORATORY	3,398	0	15,831	4,189	0
60.00	06000	LABORATORY	3,398	0	15,831	4,189	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	125	0	3,299	0	0
64.00	06400	INTRAVENOUS THERAPY	125	0	3,299	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,264	0	16,347	1,397	0
65.00	06500	RESPIRATORY THERAPY	1,264	0	16,347	1,397	65.00
66.00	06600	PHYSICAL THERAPY	1,776	0	28,471	5,396	306
66.00	06600	PHYSICAL THERAPY	1,776	0	28,471	5,396	66.00
67.00	06700	OCCUPATIONAL THERAPY	172	0	2,710	0	23
67.00	06700	OCCUPATIONAL THERAPY	172	0	2,710	0	67.00
68.00	06800	SPEECH PATHOLOGY	46	0	29	0	0
68.00	06800	SPEECH PATHOLOGY	46	0	29	0	68.00
69.00	06900	ELECTROCARDIOLOGY	209	0	6,192	2,771	0
69.00	06900	ELECTROCARDIOLOGY	209	0	6,192	2,771	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	3,730	3,743	70
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	3,730	3,743	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,126	0	73,139	1,262	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,126	0	73,139	1,262	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	16,350	0	189,724	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	16,350	0	189,724	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,036	0	41,043	2,651	0
73.00	07300	DRUGS CHARGED TO PATIENTS	5,036	0	41,043	2,651	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3	0	8,908	0	45
90.00	09000	CLINIC	3	0	8,908	0	90.00
90.01	09001	WOUND CARE INSTITUTE	2	0	413	0	4
90.01	09001	WOUND CARE INSTITUTE	2	0	413	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	395	0	0
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	395	0	90.02
90.03	09003	BIOPHYSICAL MEDICINE	0	0	0	0	0
90.03	09003	BIOPHYSICAL MEDICINE	0	0	0	0	90.03
90.04	04950	MARKETING & PLANNING	0	0	0	0	0
90.04	04950	MARKETING & PLANNING	0	0	0	0	90.04
91.00	09100	EMERGENCY	2,201	0	63,369	15,144	2,176
91.00	09100	EMERGENCY	2,201	0	63,369	15,144	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	60,392	0	901,646	164,083	10,761
118.00		SUBTOTALS (SUM OF LINES 1-117)	60,392	0	901,646	164,083	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1,913	0	0
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1,913	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	19,788	52,591	16
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	19,788	52,591	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	20,557	0	0
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	20,557	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THER	0	0	11,342	0	0
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THER	0	0	11,342	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	48,855	5,140	682
194.02	07952	JV MV ENDOSCOPY	0	0	48,855	5,140	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	2,772	0	0
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	2,772	0	194.03
200.00		Cross Foot Adjustments					
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	60,392	0	1,006,873	221,814	11,459
202.00		TOTAL (sum lines 118-201)	60,392	0	1,006,873	221,814	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 5/27/2014 12:14 pm			
Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	ADMITTING					5.01
5.02	00511	PATIENT ACCOUNTING					5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL					5.03
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING	56,588				9.00
10.00	01000	DIETARY	1,581	48,482			10.00
11.00	01100	CAFETERIA	0	0	11,099		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	43	1,596	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	91	0	14.00
15.00	01500	PHARMACY	0	0	437	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	519	0	0	0	16.00
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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,685	41,341	2,161	510	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,437	4,669	643	152	34.00
43.00	04300	NURSERY	0	2,472	189	45	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,772	0	1,574	372	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	537	127	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,964	0	1,088	0	54.00
54.01	05401	ULTRA SOUND	90	0	110	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	2,266	0	204	0	55.00
60.00	06000	LABORATORY	1,078	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	11	0	64.00
65.00	06500	RESPIRATORY THERAPY	360	0	516	0	65.00
66.00	06600	PHYSICAL THERAPY	1,389	0	962	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	111	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	714	0	27	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	964	0	70	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	325	0	0	0	389
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,047
73.00	07300	DRUGS CHARGED TO PATIENTS	682	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	210	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	14	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	15	0	90.02
90.03	09003	BARIATRIC MEDICINE	0	0	0	0	90.03
90.04	04950	MARKETING & PLANNING	0	0	0	0	90.04
91.00	09100	EMERGENCY	3,899	0	1,652	390	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	41,725	48,482	10,665	1,596	1,446
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	91	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,540	0	80	0	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	92	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THER	0	0	171	0	194.01
194.02	07952	JV MV ENDOSCOPY	1,323	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	89,575	0	0	201.00
202.00		TOTAL (sum lines 118-201)	56,588	138,057	11,099	1,596	1,446

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150057

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

Worksheet B
Part II
Date/Time Prepared:
5/27/2014 12:14 pm

Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	INTERNS & RESIDENTS		Subtotal	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
			15.00	16.00		
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 00510 ADMITTING						5.01
5.02 00511 PATIENT ACCOUNTING						5.02
5.03 00560 OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY	17,397					15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	49,533				16.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	487			21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		493		22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0	2,227			1,439,226	30.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	358			156,777	34.00
43.00 04300 NURSERY	0	143			10,457	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	5,018			903,709	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	407			22,663	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	6,955			311,375	54.00
54.01 05401 ULTRA SOUND	0	667			13,455	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	1,296			230,165	55.00
60.00 06000 LABORATORY	0	4,496			117,804	60.00
60.01 06001 BLOOD LABORATORY	0	0			0	60.01
64.00 06400 INTRAVENOUS THERAPY	0	297			3,748	64.00
65.00 06500 RESPIRATORY THERAPY	0	617			50,776	65.00
66.00 06600 PHYSICAL THERAPY	0	1,633			155,471	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	142			3,270	67.00
68.00 06800 SPEECH PATHOLOGY	0	16			91	68.00
69.00 06900 ELECTROCARDIOLOGY	0	1,040			69,767	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	381			88,434	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,033			115,023	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	5,785			212,906	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	17,397	4,050			127,065	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	395			9,906	90.00
90.01 09001 WOUND CARE INSTITUTE	0	39			490	90.01
90.02 09002 OP NUTRITIONAL COUNSELING	0	9			436	90.02
90.03 09003 BARIATRIC MEDICINE	0	0			0	90.03
90.04 04950 MARKETING & PLANNING	0	0			0	90.04
91.00 09100 EMERGENCY	0	9,529			421,743	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910 CORF	0	0			0	99.10
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	17,397	49,533	0	0	4,464,757	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			2,042	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0			1,201,211	192.00
194.00 07950 COMMUNITY RELATIONS & MARKETING	0	0			20,772	194.00
194.01 07951 PLAINFIELD RADIOLOGY & PHYSICAL THER	0	0			11,738	194.01
194.02 07952 JV MV ENDOSCOPY	0	0			164,983	194.02
194.03 07953 SOUTHWEST CENTER FOR WOMENS HEALTH	0	0			2,772	194.03
200.00 Cross Foot Adjustments			487	493	980	200.00
201.00 Negative Cost Centers	0	0	0	0	89,575	201.00
202.00 TOTAL (sum lines 118-201)	17,397	49,533	487	493	5,958,830	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 5/27/2014 12:14 pm
-------------------------------------	--	----------------------	---	---

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00510	ADMITTING		5.01
5.02	00511	PATIENT ACCOUNTING		5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL		5.03
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,439,226
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	156,777
43.00	04300	NURSERY	0	10,457
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	903,709
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	22,663
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	311,375
54.01	05401	ULTRA SOUND	0	13,455
55.00	05500	RADIOLOGY-THERAPEUTIC	0	230,165
60.00	06000	LABORATORY	0	117,804
60.01	06001	BLOOD LABORATORY	0	0
64.00	06400	INTRAVENOUS THERAPY	0	3,748
65.00	06500	RESPIRATORY THERAPY	0	50,776
66.00	06600	PHYSICAL THERAPY	0	155,471
67.00	06700	OCCUPATIONAL THERAPY	0	3,270
68.00	06800	SPEECH PATHOLOGY	0	91
69.00	06900	ELECTROCARDIOLOGY	0	69,767
70.00	07000	ELECTROENCEPHALOGRAPHY	0	88,434
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	115,023
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	212,906
73.00	07300	DRUGS CHARGED TO PATIENTS	0	127,065
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	9,906
90.01	09001	WOUND CARE INSTITUTE	0	490
90.02	09002	OP NUTRITIONAL COUNSELING	0	436
90.03	09003	BARIATRIC MEDICINE	0	0
90.04	04950	MARKETING & PLANNING	0	0
91.00	09100	EMERGENCY	0	421,743
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	4,464,757
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,042
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,201,211
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	20,772
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THER	0	11,738
194.02	07952	JV MV ENDOSCOPY	0	164,983
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	2,772
200.00		Cross Foot Adjustments	0	980
201.00		Negative Cost Centers	0	89,575
202.00		TOTAL (sum lines 118-201)	0	5,958,830

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150057

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

Worksheet B-1

Date/Time Prepared:
5/27/2014 12:14 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (INPATIENT CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	232,963				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		232,963			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	811	811	20,977,415		4.00
5.01 00510	ADMITTING	2,736	2,736	711,637	127,066,418	5.01
5.02 00511	PATIENT ACCOUNTING	0	0	0	0	301,844,950
5.03 00560	OTHER ADMINISTRATIVE AND GENERAL	6,329	6,329	900,632	0	0
7.00 00700	OPERATION OF PLANT	7,868	7,868	1,208,666	0	0
8.00 00800	LAUNDRY & LINEN SERVICE	376	376	25,664	0	0
9.00 00900	HOUSEKEEPING	1,581	1,581	883,845	0	0
10.00 01000	DIETARY	5,958	5,958	157,952	0	0
11.00 01100	CAFETERIA	0	0	291,003	0	0
13.00 01300	NURSING ADMINISTRATION	0	0	75,769	0	0
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	65,098	0	0
15.00 01500	PHARMACY	0	0	783,923	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	1,956	1,956	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
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	55,346	55,346	3,282,140	12,902,723	13,582,180
34.00 03400	SURGICAL INTENSIVE CARE UNIT	5,415	5,415	1,271,477	2,180,018	2,180,018
43.00 04300	NURSERY	0	0	340,712	874,091	874,091
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	33,058	33,058	2,004,963	21,841,729	30,600,606
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	967,260	2,468,473	2,480,451
54.00 05400	RADIOLOGY-DIAGNOSTIC	11,169	11,169	1,361,313	2,909,201	42,407,448
54.01 05401	ULTRA SOUND	340	340	206,536	256,813	4,069,738
55.00 05500	RADIOLOGY-THERAPEUTIC	8,540	8,540	315,494	109,710	7,902,220
60.00 06000	LABORATORY	4,064	4,064	0	7,153,061	27,415,031
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
64.00 06400	INTRAVENOUS THERAPY	0	0	18,867	262,886	1,810,558
65.00 06500	RESPIRATORY THERAPY	1,355	1,355	784,170	2,660,265	3,763,999
66.00 06600	PHYSICAL THERAPY	5,236	5,236	1,317,618	3,739,436	9,955,551
67.00 06700	OCCUPATIONAL THERAPY	0	0	132,365	361,625	867,684
68.00 06800	SPEECH PATHOLOGY	0	0	324	97,101	97,483
69.00 06900	ELECTROCARDIOLOGY	2,689	2,689	59,310	440,969	6,339,243
70.00 07000	ELECTROENCEPHALOGRAPHY	3,632	3,632	122,805	0	2,323,956
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,224	1,224	0	19,211,612	24,594,090
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	34,350,996	35,277,363
73.00 07300	DRUGS CHARGED TO PATIENTS	2,572	2,572	0	10,602,789	24,695,516
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	407,937	5,631	2,411,581
90.01 09001	WOUND CARE INSTITUTE	0	0	20,721	3,783	235,717
90.02 09002	OP NUTRITIONAL COUNSELING	0	0	20,419	0	56,053
90.03 09003	BIARIATRIC MEDICINE	0	0	0	0	0
90.04 04950	MARKETING & PLANNING	0	0	0	0	0
91.00 09100	EMERGENCY	14,694	14,694	2,682,561	4,633,506	57,904,373
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	176,949	176,949	20,421,181	127,066,418	301,844,950
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	45,140	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	51,027	51,027	98,695	0	0
194.00 07950	COMMUNITY RELATIONS & MARKETING	0	0	145,578	0	0
194.01 07951	PLAINFELDERADIOLOGY & PHYSICAL THER	0	0	266,821	0	0
194.02 07952	JV MV ENDOSCOPY	4,987	4,987	0	0	0
194.03 07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,918,233	2,172,795	7,134,705	1,575,405	1,289,908
203.00	Unit cost multiplier (Wkst. B, Part I)	12.526594	9.326782	0.340114	0.012398	0.004273
204.00	Cost to be allocated (per Wkst. B, Part II)			17,723	60,392	0
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000845	0.000475	0.000000

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150057

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

Worksheet B-1

Date/Time Prepared:
5/27/2014 12:14 pm

Cost Center Description		Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5A.03	5.03	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00511						5.02
5.03	00560						5.03
7.00	00700	-14,762,620	70,332,430				7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	40,236					10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500						15.00
16.00	01600						16.00
21.00	02100						21.00
22.00	02200						22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000						30.00
34.00	03400						34.00
43.00	04300						43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000						50.00
52.00	05200						52.00
54.00	05400						54.00
54.01	05401						54.01
55.00	05500						55.00
60.00	06000						60.00
60.01	06001						60.01
64.00	06400						64.00
65.00	06500						65.00
66.00	06600						66.00
67.00	06700						67.00
68.00	06800						68.00
69.00	06900						69.00
70.00	07000						70.00
71.00	07100						71.00
72.00	07200						72.00
73.00	07300						73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000						90.00
90.01	09001						90.01
90.02	09002						90.02
90.03	09003						90.03
90.04	04950						90.04
91.00	09100						91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910						99.10
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		-14,722,384	62,982,283	159,205	400,766	157,248	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000						190.00
192.00	19200						192.00
194.00	07950						194.00
194.01	07951						194.01
194.02	07952						194.02
194.03	07953						194.03
200.00							200.00
201.00							201.00
202.00			14,762,620	4,128,598	246,549	1,691,975	202.00
203.00			0.209898	19.183241	0.577728	7.933786	203.00
204.00			1,006,873	221,814	11,459	56,588	204.00
205.00			0.014316	1.030643	0.026851	0.265345	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150057

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

Worksheet B-1

Date/Time Prepared:
5/27/2014 12:14 pm

Cost Center Description		DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00511						5.02
5.03	00560						5.03
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	11,100					10.00
11.00	01100	0	523,754				11.00
13.00	01300	0	2,010	318,851			13.00
14.00	01400	0	4,281	0	17,560,548		14.00
15.00	01500	0	20,604	0	12,708	100	15.00
16.00	01600	0	0	0	0	0	16.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	9,465	102,014	102,014	19,752	0	30.00
34.00	03400	1,069	30,355	30,355	2,641	0	34.00
43.00	04300	566	8,921	8,921	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	74,292	74,292	38,532	0	50.00
52.00	05200	0	25,327	25,327	0	0	52.00
54.00	05400	0	51,331	0	15,657	0	54.00
54.01	05401	0	5,178	0	142	0	54.01
55.00	05500	0	9,618	0	386	0	55.00
60.00	06000	0	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
64.00	06400	0	532	0	1,015	0	64.00
65.00	06500	0	24,355	0	3,281	0	65.00
66.00	06600	0	45,403	0	7,139	0	66.00
67.00	06700	0	5,228	0	1,241	0	67.00
68.00	06800	0	9	0	0	0	68.00
69.00	06900	0	1,287	0	2,039	0	69.00
70.00	07000	0	3,308	0	1,690	0	70.00
71.00	07100	0	0	0	4,748,044	0	71.00
72.00	07200	0	0	0	12,676,507	0	72.00
73.00	07300	0	0	0	0	100	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	9,887	0	1,616	0	90.00
90.01	09001	0	655	0	54	0	90.01
90.02	09002	0	715	0	0	0	90.02
90.03	09003	0	0	0	0	0	90.03
90.04	04950	0	0	0	0	0	90.04
91.00	09100	0	77,942	77,942	23,588	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		11,100	503,252	318,851	17,556,032	100	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	4,315	0	30	0	190.00
192.00	19200	0	3,791	0	2,281	0	192.00
194.00	07950	0	4,318	0	377	0	194.00
194.01	07951	0	8,078	0	1,456	0	194.01
194.02	07952	0	0	0	372	0	194.02
194.03	07953	0	0	0	0	0	194.03
200.00							200.00
201.00							201.00
202.00		121,327	917,262	129,320	117,353	1,413,447	202.00
203.00		10.930360	1.751322	0.405581	0.006683	14,134.470000	203.00
204.00		138,057	11,099	1,596	1,446	17,397	204.00
205.00		4.367748	0.021191	0.005005	0.000082	173.970000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150057

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

Worksheet B-1
Date/Time Prepared:
5/27/2014 12:14 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	INTERNS & RESIDENTS			
		SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)		
		16.00	21.00		
GENERAL SERVICE COST CENTERS					
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00510 ADMITTING					5.01
5.02 00511 PATIENT ACCOUNTING					5.02
5.03 00560 OTHER ADMINISTRATIVE AND GENERAL					5.03
7.00 00700 OPERATION OF PLANT					7.00
8.00 00800 LAUNDRY & LINEN SERVICE					8.00
9.00 00900 HOUSEKEEPING					9.00
10.00 01000 DIETARY					10.00
11.00 01100 CAFETERIA					11.00
13.00 01300 NURSING ADMINISTRATION					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY					14.00
15.00 01500 PHARMACY					15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	301,844,950				16.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	100			21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0		100		22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS	13,582,180	100	100		30.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	2,180,018	0	0		34.00
43.00 04300 NURSERY	874,091	0	0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	30,600,606	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2,480,451	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	42,407,448	0	0		54.00
54.01 05401 ULTRA SOUND	4,069,738	0	0		54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	7,902,220	0	0		55.00
60.00 06000 LABORATORY	27,415,031	0	0		60.00
60.01 06001 BLOOD LABORATORY	0	0	0		60.01
64.00 06400 INTRAVENOUS THERAPY	1,810,558	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	3,763,999	0	0		65.00
66.00 06600 PHYSICAL THERAPY	9,955,551	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	867,684	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	97,483	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	6,339,243	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	2,323,956	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	24,594,090	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	35,277,363	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	24,695,516	0	0		73.00
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	2,411,581	0	0		90.00
90.01 09001 WOUND CARE INSTITUTE	235,717	0	0		90.01
90.02 09002 OP NUTRITIONAL COUNSELING	56,053	0	0		90.02
90.03 09003 BARIATRIC MEDICINE	0	0	0		90.03
90.04 04950 MARKETING & PLANNING	0	0	0		90.04
91.00 09100 EMERGENCY	57,904,373	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS					
99.10 09910 CORF	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	301,844,950	100	100	118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
194.00 07950 COMMUNITY RELATIONS & MARKETING	0	0	0		194.00
194.01 07951 PLAINFIELD RADIOLOGY & PHYSICAL THER	0	0	0		194.01
194.02 07952 JV MV ENDOSCOPY	0	0	0		194.02
194.03 07953 SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0		194.03
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)	412,449	41,126	41,625	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.001366	411.260000	416.250000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	49,533	487	493	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000164	4.870000	4.930000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150057

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

Worksheet C
Part I
Date/Time Prepared:
5/27/2014 12:14 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	RCE			
					Disallowance	Total Costs		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,400,549		10,400,549	0	10,400,549	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	2,077,738		2,077,738	2,425	2,080,163	34.00
43.00	04300	NURSERY	610,221		610,221	0	610,221	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,027,505		11,027,505	0	11,027,505	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,714,659		1,714,659	0	1,714,659	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,952,348		3,952,348	18,299	3,970,647	54.00
54.01	05401	ULTRA SOUND	405,085		405,085	0	405,085	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	2,838,124		2,838,124	0	2,838,124	55.00
60.00	06000	LABORATORY	1,485,569		1,485,569	0	1,485,569	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	282,204		282,204	0	282,204	64.00
65.00	06500	RESPIRATORY THERAPY	1,466,116	0	1,466,116	0	1,466,116	65.00
66.00	06600	PHYSICAL THERAPY	2,647,902	0	2,647,902	0	2,647,902	66.00
67.00	06700	OCCUPATIONAL THERAPY	239,905	0	239,905	0	239,905	67.00
68.00	06800	SPEECH PATHOLOGY	2,635	0	2,635	0	2,635	68.00
69.00	06900	ELECTROCARDIOLOGY	607,180		607,180	0	607,180	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	424,187		424,187	0	424,187	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,279,785		6,279,785	0	6,279,785	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	16,167,864		16,167,864	0	16,167,864	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,985,661		4,985,661	0	4,985,661	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	774,471		774,471	0	774,471	90.00
90.01	09001	WOUND CARE INSTITUTE	36,503		36,503	0	36,503	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	34,727		34,727	0	34,727	90.02
90.03	09003	BARIATRIC MEDICINE	0		0	0	0	90.03
90.04	04950	MARKETING & PLANNING	0		0	0	0	90.04
91.00	09100	EMERGENCY	6,048,313		6,048,313	1,341	6,049,654	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	582,935		582,935	0	582,935	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	75,092,186	0	75,092,186	22,065	75,114,251	200.00
201.00		Less Observation Beds	582,935		582,935		582,935	201.00
202.00		Total (see instructions)	74,509,251	0	74,509,251	22,065	74,531,316	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150057

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

Worksheet C
Part I
Date/Time Prepared:
5/27/2014 12:14 pm

		Title XVIII			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,679,220		12,679,220		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	2,180,018		2,180,018		34.00
43.00	04300	NURSERY	874,091		874,091		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	21,841,729	8,758,877	30,600,606	0.360369	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,468,473	11,978	2,480,451	0.691269	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,909,201	39,498,247	42,407,448	0.093199	54.00
54.01	05401	ULTRA SOUND	256,813	3,812,925	4,069,738	0.099536	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	109,710	7,792,510	7,902,220	0.359155	55.00
60.00	06000	LABORATORY	7,153,061	20,261,970	27,415,031	0.054188	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	262,886	1,547,672	1,810,558	0.155866	64.00
65.00	06500	RESPIRATORY THERAPY	2,660,265	1,103,734	3,763,999	0.389510	65.00
66.00	06600	PHYSICAL THERAPY	3,739,436	6,216,115	9,955,551	0.265972	66.00
67.00	06700	OCCUPATIONAL THERAPY	361,625	506,059	867,684	0.276489	67.00
68.00	06800	SPEECH PATHOLOGY	97,101	382	97,483	0.027030	68.00
69.00	06900	ELECTROCARDIOLOGY	440,969	5,898,274	6,339,243	0.095781	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,323,956	2,323,956	0.182528	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,211,612	5,382,478	24,594,090	0.255337	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	34,350,996	926,367	35,277,363	0.458307	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,602,789	14,092,727	24,695,516	0.201885	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	5,631	2,405,950	2,411,581	0.321147	90.00
90.01	09001	WOUND CARE INSTITUTE	3,783	231,934	235,717	0.154859	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	56,053	56,053	0.619539	90.02
90.03	09003	BARIATRIC MEDICINE	0	0	0	0.000000	90.03
90.04	04950	MARKETING & PLANNING	0	0	0	0.000000	90.04
91.00	09100	EMERGENCY	4,633,506	53,270,867	57,904,373	0.104453	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	223,503	679,457	902,960	0.645582	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	127,066,418	174,778,532	301,844,950		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	127,066,418	174,778,532	301,844,950		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/27/2014 12:14 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT			34.00
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.360369		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.691269		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.093631		54.00
54.01	05401 ULTRA SOUND	0.099536		54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.359155		55.00
60.00	06000 LABORATORY	0.054188		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
64.00	06400 INTRAVENOUS THERAPY	0.155866		64.00
65.00	06500 RESPIRATORY THERAPY	0.389510		65.00
66.00	06600 PHYSICAL THERAPY	0.265972		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.276489		67.00
68.00	06800 SPEECH PATHOLOGY	0.027030		68.00
69.00	06900 ELECTROCARDIOLOGY	0.095781		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.182528		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.255337		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.458307		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.201885		73.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.321147		90.00
90.01	09001 WOUND CARE INSTITUTE	0.154859		90.01
90.02	09002 OP NUTRITIONAL COUNSELING	0.619539		90.02
90.03	09003 BARIATRIC MEDICINE	0.000000		90.03
90.04	04950 MARKETING & PLANNING	0.000000		90.04
91.00	09100 EMERGENCY	0.104477		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.645582		92.00
	OTHER REIMBURSABLE COST CENTERS			
99.10	09910 CORF			99.10
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150057		Period: From 01/01/2013 To 12/31/2013		Worksheet C Part I Date/Time Prepared: 5/27/2014 12:14 pm		
		Title XIX		Hospital		PPS		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	RCE Disallowance	Total Costs		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,400,549		10,400,549	0	10,400,549	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	2,077,738		2,077,738	2,425	2,080,163	34.00
43.00	04300	NURSERY	610,221		610,221	0	610,221	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,027,505		11,027,505	0	11,027,505	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,714,659		1,714,659	0	1,714,659	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,952,348		3,952,348	18,299	3,970,647	54.00
54.01	05401	ULTRA SOUND	405,085		405,085	0	405,085	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	2,838,124		2,838,124	0	2,838,124	55.00
60.00	06000	LABORATORY	1,485,569		1,485,569	0	1,485,569	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	282,204		282,204	0	282,204	64.00
65.00	06500	RESPIRATORY THERAPY	1,466,116	0	1,466,116	0	1,466,116	65.00
66.00	06600	PHYSICAL THERAPY	2,647,902	0	2,647,902	0	2,647,902	66.00
67.00	06700	OCCUPATIONAL THERAPY	239,905	0	239,905	0	239,905	67.00
68.00	06800	SPEECH PATHOLOGY	2,635	0	2,635	0	2,635	68.00
69.00	06900	ELECTROCARDIOLOGY	607,180		607,180	0	607,180	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	424,187		424,187	0	424,187	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,279,785		6,279,785	0	6,279,785	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	16,167,864		16,167,864	0	16,167,864	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,985,661		4,985,661	0	4,985,661	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	774,471		774,471	0	774,471	90.00
90.01	09001	WOUND CARE INSTITUTE	36,503		36,503	0	36,503	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	34,727		34,727	0	34,727	90.02
90.03	09003	BARIATRIC MEDICINE	0		0	0	0	90.03
90.04	04950	MARKETING & PLANNING	0		0	0	0	90.04
91.00	09100	EMERGENCY	6,048,313		6,048,313	1,341	6,049,654	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	582,935		582,935	0	582,935	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	75,092,186	0	75,092,186	22,065	75,114,251	200.00
201.00		Less Observation Beds	582,935		582,935		582,935	201.00
202.00		Total (see instructions)	74,509,251	0	74,509,251	22,065	74,531,316	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 150057		Period: From 01/01/2013 To 12/31/2013		Worksheet C Part I Date/Time Prepared: 5/27/2014 12:14 pm	
			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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,679,220		12,679,220			30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	2,180,018		2,180,018			34.00
43.00	04300	NURSERY	874,091		874,091			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	21,841,729	8,758,877	30,600,606	0.360369	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,468,473	11,978	2,480,451	0.691269	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,909,201	39,498,247	42,407,448	0.093199	0.000000	54.00
54.01	05401	ULTRA SOUND	256,813	3,812,925	4,069,738	0.099536	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	109,710	7,792,510	7,902,220	0.359155	0.000000	55.00
60.00	06000	LABORATORY	7,153,061	20,261,970	27,415,031	0.054188	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	262,886	1,547,672	1,810,558	0.155866	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	2,660,265	1,103,734	3,763,999	0.389510	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,739,436	6,216,115	9,955,551	0.265972	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	361,625	506,059	867,684	0.276489	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	97,101	382	97,483	0.027030	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	440,969	5,898,274	6,339,243	0.095781	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,323,956	2,323,956	0.182528	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,211,612	5,382,478	24,594,090	0.255337	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	34,350,996	926,367	35,277,363	0.458307	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,602,789	14,092,727	24,695,516	0.201885	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	5,631	2,405,950	2,411,581	0.321147	0.000000	90.00
90.01	09001	WOUND CARE INSTITUTE	3,783	231,934	235,717	0.154859	0.000000	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	56,053	56,053	0.619539	0.000000	90.02
90.03	09003	BARITRIC MEDICINE	0	0	0	0.000000	0.000000	90.03
90.04	04950	MARKETING & PLANNING	0	0	0	0.000000	0.000000	90.04
91.00	09100	EMERGENCY	4,633,506	53,270,867	57,904,373	0.104453	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	223,503	679,457	902,960	0.645582	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	127,066,418	174,778,532	301,844,950			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	127,066,418	174,778,532	301,844,950			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/27/2014 12:14 pm
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT			34.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.360369		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.691269		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.093631		54.00
54.01	05401 ULTRA SOUND	0.099536		54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.359155		55.00
60.00	06000 LABORATORY	0.054188		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
64.00	06400 INTRAVENOUS THERAPY	0.155866		64.00
65.00	06500 RESPIRATORY THERAPY	0.389510		65.00
66.00	06600 PHYSICAL THERAPY	0.265972		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.276489		67.00
68.00	06800 SPEECH PATHOLOGY	0.027030		68.00
69.00	06900 ELECTROCARDIOLOGY	0.095781		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.182528		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.255337		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.458307		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.201885		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.321147		90.00
90.01	09001 WOUND CARE INSTITUTE	0.154859		90.01
90.02	09002 OP NUTRITIONAL COUNSELING	0.619539		90.02
90.03	09003 BARIATRIC MEDICINE	0.000000		90.03
90.04	04950 MARKETING & PLANNING	0.000000		90.04
91.00	09100 EMERGENCY	0.104477		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.645582		92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910 CORF			99.10
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

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

Provider CCN: 150057

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

Worksheet C Part II Date/Time Prepared: 5/27/2014 12:14 pm

Cost Center Description			Title XIX			Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,027,505	903,709	10,123,796	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,714,659	22,663	1,691,996	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,952,348	311,375	3,640,973	0	0	54.00
54.01	05401	ULTRA SOUND	405,085	13,455	391,630	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	2,838,124	230,165	2,607,959	0	0	55.00
60.00	06000	LABORATORY	1,485,569	117,804	1,367,765	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	282,204	3,748	278,456	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,466,116	50,776	1,415,340	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,647,902	155,471	2,492,431	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	239,905	3,270	236,635	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,635	91	2,544	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	607,180	69,767	537,413	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	424,187	88,434	335,753	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,279,785	115,023	6,164,762	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	16,167,864	212,906	15,954,958	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,985,661	127,065	4,858,596	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	774,471	9,906	764,565	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	36,503	490	36,013	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	34,727	436	34,291	0	0	90.02
90.03	09003	BARIATRIC MEDICINE	0	0	0	0	0	90.03
90.04	04950	MARKETING & PLANNING	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	6,048,313	421,743	5,626,570	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	582,935	80,667	502,268	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	62,003,678	2,938,964	59,064,714	0	0	200.00
201.00		Less Observation Beds	582,935	80,667	502,268	0	0	201.00
202.00		Total (line 200 minus line 201)	61,420,743	2,858,297	58,562,446	0	0	202.00

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

Provider CCN: 150057

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

Worksheet C Part II Date/Time Prepared: 5/27/2014 12:14 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
		6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	11,027,505	30,600,606	0.360369	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,714,659	2,480,451	0.691269	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,952,348	42,407,448	0.093199	54.00
54.01	05401 ULTRA SOUND	405,085	4,069,738	0.099536	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	2,838,124	7,902,220	0.359155	55.00
60.00	06000 LABORATORY	1,485,569	27,415,031	0.054188	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	60.01
64.00	06400 INTRAVENOUS THERAPY	282,204	1,810,558	0.155866	64.00
65.00	06500 RESPIRATORY THERAPY	1,466,116	3,763,999	0.389510	65.00
66.00	06600 PHYSICAL THERAPY	2,647,902	9,955,551	0.265972	66.00
67.00	06700 OCCUPATIONAL THERAPY	239,905	867,684	0.276489	67.00
68.00	06800 SPEECH PATHOLOGY	2,635	97,483	0.027030	68.00
69.00	06900 ELECTROCARDIOLOGY	607,180	6,339,243	0.095781	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	424,187	2,323,956	0.182528	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6,279,785	24,594,090	0.255337	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	16,167,864	35,277,363	0.458307	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,985,661	24,695,516	0.201885	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	774,471	2,411,581	0.321147	90.00
90.01	09001 WOUND CARE INSTITUTE	36,503	235,717	0.154859	90.01
90.02	09002 OP NUTRITIONAL COUNSELING	34,727	56,053	0.619539	90.02
90.03	09003 BARIATRIC MEDICINE	0	0	0.000000	90.03
90.04	04950 MARKETING & PLANNING	0	0	0.000000	90.04
91.00	09100 EMERGENCY	6,048,313	57,904,373	0.104453	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	582,935	902,960	0.645582	92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910 CORF	0	0	0.000000	99.10
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (sum of lines 50 thru 199)	62,003,678	286,111,621		200.00
201.00	Less Observation Beds	582,935	0		201.00
202.00	Total (line 200 minus line 201)	61,420,743	286,111,621		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150057		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part I Date/Time Prepared: 5/27/2014 12:14 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	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	1,439,226	0	1,439,226	10,027	143.54	30.00
34.00	SURGICAL INTENSIVE CARE UNIT	156,777		156,777	1,069	146.66	34.00
43.00	NURSERY	10,457		10,457	566	18.48	43.00
200.00	Total (Lines 30-199)	1,606,460		1,606,460	11,662		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	4,623	663,585				
34.00	SURGICAL INTENSIVE CARE UNIT	653	95,769				
43.00	NURSERY	0	0				
200.00	Total (Lines 30-199)	5,276	759,354				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/27/2014 12:14 pm
--	--	----------------------	---	---

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	903,709	30,600,606	0.029532	10,544,993	311,415	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	22,663	2,480,451	0.009137	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	311,375	42,407,448	0.007342	1,690,085	12,409	54.00
54.01	05401 ULTRA SOUND	13,455	4,069,738	0.003306	95,376	315	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	230,165	7,902,220	0.029127	51,029	1,486	55.00
60.00	06000 LABORATORY	117,804	27,415,031	0.004297	3,528,075	15,160	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	3,748	1,810,558	0.002070	168,305	348	64.00
65.00	06500 RESPIRATORY THERAPY	50,776	3,763,999	0.013490	1,440,944	19,438	65.00
66.00	06600 PHYSICAL THERAPY	155,471	9,955,551	0.015617	1,993,490	31,132	66.00
67.00	06700 OCCUPATIONAL THERAPY	3,270	867,684	0.003769	179,642	677	67.00
68.00	06800 SPEECH PATHOLOGY	91	97,483	0.000933	14,247	13	68.00
69.00	06900 ELECTROCARDIOLOGY	69,767	6,339,243	0.011006	274,837	3,025	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	88,434	2,323,956	0.038053	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	115,023	24,594,090	0.004677	9,319,635	43,588	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	212,906	35,277,363	0.006035	16,880,292	101,873	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	127,065	24,695,516	0.005145	5,101,812	26,249	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	9,906	2,411,581	0.004108	3,897	16	90.00
90.01	09001 WOUND CARE INSTITUTE	490	235,717	0.002079	1,559	3	90.01
90.02	09002 OP NUTRITIONAL COUNSELING	436	56,053	0.007778	0	0	90.02
90.03	09003 BARIATRIC MEDICINE	0	0	0.000000	0	0	90.03
90.04	04950 MARKETING & PLANNING	0	0	0.000000	0	0	90.04
91.00	09100 EMERGENCY	421,743	57,904,373	0.007283	2,284,182	16,636	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	80,667	902,960	0.089336	130,922	11,696	92.00
200.00	Total (lines 50-199)	2,938,964	286,111,621		53,703,322	595,479	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150057		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part III Date/Time Prepared: 5/27/2014 12:14 pm	
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
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
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	10,027	0.00	4,623	0		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,069	0.00	653	0		34.00
43.00	04300	NURSERY	566	0.00	0	0		43.00
200.00		Total (lines 30-199)	11,662		5,276	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150057

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

Worksheet D
Part IV
Date/Time Prepared:
5/27/2014 12:14 pm

Cost Center Description		Title XVIII				Hospital		PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	0	0	90.02
90.03	09003	BARIATRIC MEDICINE	0	0	0	0	0	90.03
90.04	04950	MARKETING & PLANNING	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/27/2014 12:14 pm
--	----------------------	---	---

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	30,600,606	0.000000	0.000000	10,544,993	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	2,480,451	0.000000	0.000000	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	42,407,448	0.000000	0.000000	1,690,085	54.00
54.01	05401 ULTRA SOUND	0	4,069,738	0.000000	0.000000	95,376	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	7,902,220	0.000000	0.000000	51,029	55.00
60.00	06000 LABORATORY	0	27,415,031	0.000000	0.000000	3,528,075	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	1,810,558	0.000000	0.000000	168,305	64.00
65.00	06500 RESPIRATORY THERAPY	0	3,763,999	0.000000	0.000000	1,440,944	65.00
66.00	06600 PHYSICAL THERAPY	0	9,955,551	0.000000	0.000000	1,993,490	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	867,684	0.000000	0.000000	179,642	67.00
68.00	06800 SPEECH PATHOLOGY	0	97,483	0.000000	0.000000	14,247	68.00
69.00	06900 ELECTROCARDIOLOGY	0	6,339,243	0.000000	0.000000	274,837	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2,323,956	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	24,594,090	0.000000	0.000000	9,319,635	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	35,277,363	0.000000	0.000000	16,880,292	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	24,695,516	0.000000	0.000000	5,101,812	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	2,411,581	0.000000	0.000000	3,897	90.00
90.01	09001 WOUND CARE INSTITUTE	0	235,717	0.000000	0.000000	1,559	90.01
90.02	09002 OP NUTRITIONAL COUNSELING	0	56,053	0.000000	0.000000	0	90.02
90.03	09003 BARIATRIC MEDICINE	0	0	0.000000	0.000000	0	90.03
90.04	04950 MARKETING & PLANNING	0	0	0.000000	0.000000	0	90.04
91.00	09100 EMERGENCY	0	57,904,373	0.000000	0.000000	2,284,182	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	902,960	0.000000	0.000000	130,922	92.00
200.00	Total (lines 50-199)	0	286,111,621			53,703,322	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/27/2014 12:14 pm
--	----------------------	---	---

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XVIII Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	1,271,141	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	15,578,891	0	54.00
54.01	05401 ULTRA SOUND	0	1,293,832	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	4,365,375	0	55.00
60.00	06000 LABORATORY	0	241,846	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	389,484	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	408,733	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	2,809,225	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	586,286	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	808,206	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	232,364	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	11,757,753	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	1,011,632	0	90.00
90.01	09001 WOUND CARE INSTITUTE	0	136,131	0	90.01
90.02	09002 OP NUTRITIONAL COUNSELING	0	0	0	90.02
90.03	09003 BARIATRIC MEDICINE	0	0	0	90.03
90.04	04950 MARKETING & PLANNING	0	0	0	90.04
91.00	09100 EMERGENCY	0	9,274,032	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	199,011	0	92.00
200.00	Total (lines 50-199)	0	50,363,942	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 12:14 pm
--	----------------------	---	--

		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	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.360369	1,271,141	0	0	458,080	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.691269	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.093199	15,578,891	0	0	1,451,937	54.00
54.01	05401 ULTRA SOUND	0.099536	1,293,832	0	0	128,783	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.359155	4,365,375	0	0	1,567,846	55.00
60.00	06000 LABORATORY	0.054188	241,846	6,158	0	13,105	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0.155866	389,484	0	0	60,707	64.00
65.00	06500 RESPIRATORY THERAPY	0.389510	408,733	0	0	159,206	65.00
66.00	06600 PHYSICAL THERAPY	0.265972	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.276489	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.027030	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.095781	2,809,225	0	0	269,070	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.182528	586,286	0	0	107,014	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.255337	808,206	1,828	0	206,365	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.458307	232,364	0	0	106,494	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.201885	11,757,753	7,605	0	2,373,714	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.321147	1,011,632	0	0	324,883	90.00
90.01	09001 WOUND CARE INSTITUTE	0.154859	136,131	0	0	21,081	90.01
90.02	09002 OP NUTRITIONAL COUNSELING	0.619539	0	0	0	0	90.02
90.03	09003 BARIATRIC MEDICINE	0.000000	0	0	0	0	90.03
90.04	04950 MARKETING & PLANNING	0.000000	0	0	0	0	90.04
91.00	09100 EMERGENCY	0.104453	9,274,032	0	0	968,700	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.645582	199,011	0	0	128,478	92.00
200.00	Subtotal (see instructions)		50,363,942	15,591	0	8,345,463	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (Line 200 +/- Line 201)		50,363,942	15,591	0	8,345,463	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 12:14 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs		Hospital	PPS
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 05401 ULTRA SOUND	0	0		54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
60.00 06000 LABORATORY	334	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
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	467	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,535	0		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 WOUND CARE INSTITUTE	0	0		90.01
90.02 09002 OP NUTRITIONAL COUNSELING	0	0		90.02
90.03 09003 BARIATRIC MEDICINE	0	0		90.03
90.04 04950 MARKETING & PLANNING	0	0		90.04
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)	2,336	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (Line 200 +/- Line 201)	2,336	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150057		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part I Date/Time Prepared: 5/27/2014 12:14 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,439,226	0	1,439,226	10,027	143.54	30.00
34.00	SURGICAL INTENSIVE CARE UNIT	156,777		156,777	1,069	146.66	34.00
43.00	NURSERY	10,457		10,457	566	18.48	43.00
200.00	Total (Lines 30-199)	1,606,460		1,606,460	11,662		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	310	44,497				
34.00	SURGICAL INTENSIVE CARE UNIT	36	5,280				
43.00	NURSERY	19	351				
200.00	Total (Lines 30-199)	365	50,128				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/27/2014 12:14 pm
--	--	----------------------	---	---

Cost Center Description		Title XIX			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	903,709	30,600,606	0.029532	628,413	18,558	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	22,663	2,480,451	0.009137	1,129,927	10,324	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	311,375	42,407,448	0.007342	172,026	1,263	54.00
54.01	05401	ULTRA SOUND	13,455	4,069,738	0.003306	33,273	110	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	230,165	7,902,220	0.029127	0	0	55.00
60.00	06000	LABORATORY	117,804	27,415,031	0.004297	530,585	2,280	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	3,748	1,810,558	0.002070	19,936	41	64.00
65.00	06500	RESPIRATORY THERAPY	50,776	3,763,999	0.013490	168,100	2,268	65.00
66.00	06600	PHYSICAL THERAPY	155,471	9,955,551	0.015617	91,633	1,431	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,270	867,684	0.003769	6,748	25	67.00
68.00	06800	SPEECH PATHOLOGY	91	97,483	0.000933	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	69,767	6,339,243	0.011006	18,990	209	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	88,434	2,323,956	0.038053	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	115,023	24,594,090	0.004677	743,138	3,476	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	212,906	35,277,363	0.006035	715,749	4,320	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	127,065	24,695,516	0.005145	613,312	3,155	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	9,906	2,411,581	0.004108	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	490	235,717	0.002079	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	436	56,053	0.007778	0	0	90.02
90.03	09003	BARIATRIC MEDICINE	0	0	0.000000	0	0	90.03
90.04	04950	MARKETING & PLANNING	0	0	0.000000	0	0	90.04
91.00	09100	EMERGENCY	421,743	57,904,373	0.007283	308,238	2,245	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	80,667	902,960	0.089336	23,263	2,078	92.00
200.00		Total (lines 50-199)	2,938,964	286,111,621		5,203,331	51,783	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150057		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part III Date/Time Prepared: 5/27/2014 12:14 pm	
Cost Center Description			Title XIX			Hospital		PPS
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
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	10,027	0.00	310	0		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,069	0.00	36	0		34.00
43.00	04300	NURSERY	566	0.00	19	0		43.00
200.00		Total (lines 30-199)	11,662		365	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150057

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

Worksheet D
Part IV
Date/Time Prepared:
5/27/2014 12:14 pm

Cost Center Description		Title XIX			Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	0	0	90.02
90.03	09003	BARIATRIC MEDICINE	0	0	0	0	0	90.03
90.04	04950	MARKETING & PLANNING	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/27/2014 12:14 pm
--	----------------------	---------------------------------------	--

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	PPS
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	30,600,606	0.000000	0.000000	628,413	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	2,480,451	0.000000	0.000000	1,129,927	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	42,407,448	0.000000	0.000000	172,026	54.00
54.01	05401 ULTRA SOUND	0	4,069,738	0.000000	0.000000	33,273	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	7,902,220	0.000000	0.000000	0	55.00
60.00	06000 LABORATORY	0	27,415,031	0.000000	0.000000	530,585	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	1,810,558	0.000000	0.000000	19,936	64.00
65.00	06500 RESPIRATORY THERAPY	0	3,763,999	0.000000	0.000000	168,100	65.00
66.00	06600 PHYSICAL THERAPY	0	9,955,551	0.000000	0.000000	91,633	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	867,684	0.000000	0.000000	6,748	67.00
68.00	06800 SPEECH PATHOLOGY	0	97,483	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	6,339,243	0.000000	0.000000	18,990	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2,323,956	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	24,594,090	0.000000	0.000000	743,138	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	35,277,363	0.000000	0.000000	715,749	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	24,695,516	0.000000	0.000000	613,312	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	2,411,581	0.000000	0.000000	0	90.00
90.01	09001 WOUND CARE INSTITUTE	0	235,717	0.000000	0.000000	0	90.01
90.02	09002 OP NUTRITIONAL COUNSELING	0	56,053	0.000000	0.000000	0	90.02
90.03	09003 BARIATRIC MEDICINE	0	0	0.000000	0.000000	0	90.03
90.04	04950 MARKETING & PLANNING	0	0	0.000000	0.000000	0	90.04
91.00	09100 EMERGENCY	0	57,904,373	0.000000	0.000000	308,238	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	902,960	0.000000	0.000000	23,263	92.00
200.00	Total (lines 50-199)	0	286,111,621			5,203,331	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/27/2014 12:14 pm
--	----------------------	---	---

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XIX Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	05401 ULTRA SOUND	0	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
60.00	06000 LABORATORY	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
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 PATIENT	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0	90.00
90.01	09001 WOUND CARE INSTITUTE	0	0	0	90.01
90.02	09002 OP NUTRITIONAL COUNSELING	0	0	0	90.02
90.03	09003 BARIATRIC MEDICINE	0	0	0	90.03
90.04	04950 MARKETING & PLANNING	0	0	0	90.04
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 12:14 pm
	Title XIX	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.360369	0	299,033	0	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.691269	0	7,910	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.093199	0	4,227,709	0	0
54.01 05401 ULTRA SOUND	0.099536	0	732,750	0	0
55.00 05500 RADIOLOGY-THERAPEUTIC	0.359155	0	114,464	0	0
60.00 06000 LABORATORY	0.054188	0	2,518,029	0	0
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0
64.00 06400 INTRAVENOUS THERAPY	0.155866	0	25,813	0	0
65.00 06500 RESPIRATORY THERAPY	0.389510	0	140,631	0	0
66.00 06600 PHYSICAL THERAPY	0.265972	0	689,770	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.276489	0	43,513	0	0
68.00 06800 SPEECH PATHOLOGY	0.027030	0	0	0	0
69.00 06900 ELECTROCARDIOLOGY	0.095781	0	344,844	0	0
70.00 07000 ELECTROENCEPHALOGRAPHY	0.182528	0	442,362	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.255337	0	401,111	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.458307	0	32,426	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.201885	0	1,542,950	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0.321147	0	172,578	0	0
90.01 09001 WOUND CARE INSTITUTE	0.154859	0	9,093	0	0
90.02 09002 OP NUTRITIONAL COUNSELING	0.619539	0	13,630	0	0
90.03 09003 BARIATRIC MEDICINE	0.000000	0	0	0	0
90.04 04950 MARKETING & PLANNING	0.000000	0	0	0	0
91.00 09100 EMERGENCY	0.104453	0	12,988,944	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.645582	0	84,160	0	0
200.00 Subtotal (see instructions)		0	24,831,720	0	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00 Net Charges (line 200 +/- line 201)		0	24,831,720	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 12:14 pm
	Title XIX	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	107,762	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	5,468	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	394,018	0		54.00
54.01 05401 ULTRA SOUND	72,935	0		54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	41,110	0		55.00
60.00 06000 LABORATORY	136,447	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
64.00 06400 INTRAVENOUS THERAPY	4,023	0		64.00
65.00 06500 RESPIRATORY THERAPY	54,777	0		65.00
66.00 06600 PHYSICAL THERAPY	183,460	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	12,031	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	33,030	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	80,743	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	102,418	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	14,861	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	311,498	0		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	55,423	0		90.00
90.01 09001 WOUND CARE INSTITUTE	1,408	0		90.01
90.02 09002 OP NUTRITIONAL COUNSELING	8,444	0		90.02
90.03 09003 BARIATRIC MEDICINE	0	0		90.03
90.04 04950 MARKETING & PLANNING	0	0		90.04
91.00 09100 EMERGENCY	1,356,734	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	54,332	0		92.00
200.00 Subtotal (see instructions)	3,030,922	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (Line 200 +/- Line 201)	3,030,922	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/27/2014 12:14 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		10,027	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		10,027	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)		9,465	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)		4,623	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		10,400,549	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)		10,400,549	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		10,400,549	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,037.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,795,207	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)		4,795,207	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/27/2014 12:14 pm	
Cost Center Description			Title XVIII		Hospital	
Intensive Care Type Inpatient Hospital Units			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)	0	0	0.00	0	42.00
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT	2,080,163	1,069	1,945.90	653	1,270,673
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				16,842,059	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				22,907,939	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				759,354	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				595,479	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				1,354,833	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				21,553,106	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges				0	54.00
55.00	Target amount per discharge				0.00	55.00
56.00	Target amount (line 54 x line 55)				0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0	57.00
58.00	Bonus payment (see instructions)				0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0	61.00
62.00	Relief payment (see instructions)				0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)				562	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,037.25	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				582,935	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150057		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/27/2014 12:14 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,439,226	10,400,549	0.138380	582,935	80,667	90.00
91.00	Nursing School cost	0	10,400,549	0.000000	582,935	0	91.00
92.00	Allied health cost	0	10,400,549	0.000000	582,935	0	92.00
93.00	All other Medical Education	0	10,400,549	0.000000	582,935	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/27/2014 12:14 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		10,027	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		10,027	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)		9,465	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)		310	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)		566	15.00
16.00	Nursery days (title V or XIX only)		19	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		10,400,549	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)		10,400,549	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		10,400,549	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,037.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		321,548	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)		321,548	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/27/2014 12:14 pm		
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)		
42.00	NURSERY (title V & XIX only)	610,221	566	1,078.13	19	20,484	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	2,080,163	1,069	1,945.90	36	70,052	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)					1,841,180	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,253,264	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					50,128	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					51,783	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					101,911	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,151,353	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					562	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,037.25	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					582,935	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150057		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/27/2014 12:14 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,439,226	10,400,549	0.138380	582,935	80,667	90.00
91.00	Nursing School cost	0	10,400,549	0.000000	582,935	0	91.00
92.00	Allied health cost	0	10,400,549	0.000000	582,935	0	92.00
93.00	All other Medical Education	0	10,400,549	0.000000	582,935	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/27/2014 12:14 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		6,337,503		30.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT		1,259,655		34.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.360369	10,544,993	3,800,089	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.691269	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.093631	1,690,085	158,244	54.00
54.01	05401 ULTRA SOUND	0.099536	95,376	9,493	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.359155	51,029	18,327	55.00
60.00	06000 LABORATORY	0.054188	3,528,075	191,179	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0.155866	168,305	26,233	64.00
65.00	06500 RESPIRATORY THERAPY	0.389510	1,440,944	561,262	65.00
66.00	06600 PHYSICAL THERAPY	0.265972	1,993,490	530,213	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.276489	179,642	49,669	67.00
68.00	06800 SPEECH PATHOLOGY	0.027030	14,247	385	68.00
69.00	06900 ELECTROCARDIOLOGY	0.095781	274,837	26,324	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.182528	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.255337	9,319,635	2,379,648	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.458307	16,880,292	7,736,356	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.201885	5,101,812	1,029,979	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.321147	3,897	1,252	90.00
90.01	09001 WOUND CARE INSTITUTE	0.154859	1,559	241	90.01
90.02	09002 OP NUTRITIONAL COUNSELING	0.619539	0	0	90.02
90.03	09003 BARIATRIC MEDICINE	0.000000	0	0	90.03
90.04	04950 MARKETING & PLANNING	0.000000	0	0	90.04
91.00	09100 EMERGENCY	0.104477	2,284,182	238,644	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.645582	130,922	84,521	92.00
200.00	Total (sum of lines 50-94 and 96-98)		53,703,322	16,842,059	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)		53,703,322		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3	
		Title XIX	Hospital	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		887,403	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		103,313	34.00
43.00	04300	NURSERY		518,305	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.360369	628,413	226,461 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.691269	1,129,927	781,084 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.093631	172,026	16,107 54.00
54.01	05401	ULTRA SOUND	0.099536	33,273	3,312 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.359155	0	0 55.00
60.00	06000	LABORATORY	0.054188	530,585	28,751 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
64.00	06400	INTRAVENOUS THERAPY	0.155866	19,936	3,107 64.00
65.00	06500	RESPIRATORY THERAPY	0.389510	168,100	65,477 65.00
66.00	06600	PHYSICAL THERAPY	0.265972	91,633	24,372 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.276489	6,748	1,866 67.00
68.00	06800	SPEECH PATHOLOGY	0.027030	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.095781	18,990	1,819 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.182528	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.255337	743,138	189,751 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.458307	715,749	328,033 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.201885	613,312	123,818 73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.321147	0	0 90.00
90.01	09001	WOUND CARE INSTITUTE	0.154859	0	0 90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0.619539	0	0 90.02
90.03	09003	BARIATRIC MEDICINE	0.000000	0	0 90.03
90.04	04950	MARKETING & PLANNING	0.000000	0	0 90.04
91.00	09100	EMERGENCY	0.104477	308,238	32,204 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.645582	23,263	15,018 92.00
200.00		Total (sum of lines 50-94 and 96-98)		5,203,331	1,841,180 200.00
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)		5,203,331	1,841,180 202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/27/2014 12:14 pm
		Title XVII	Hospital	PPS
		0	1.00	2.00
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013 (see instructions)		11,327,886	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		3,872,531	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)		183,089	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		3,646,370	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		98.70	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.75	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)		0.75	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.46	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)		0.46	12.00
13.00	Total allowable FTE count for the prior year.		0.34	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.		0.33	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.38	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		0.38	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.003850	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.003450	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.003450	21.00
22.00	IME payment adjustment (see instructions)		35,526	22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		35,526	29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		0.00	30.00
31.00	Percentage of Medicaid patient days (see instructions)		0.00	31.00
32.00	Sum of lines 30 and 31		0.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00	33.00
34.00	Disproportionate share adjustment (see instructions)		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/27/2014 12:14 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1	On/After October 1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)			9,046,380,143	35.00
35.01	Factor 3 (see instructions)			0.000046473	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)			0	36.00
Additional payment for high percentage of ESRD beneficiary discharges					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)			0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)			0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)			0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)			0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)			0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)			0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)			0	46.00
47.00	Subtotal (see instructions)			15,419,032	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)			15,419,032	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)			1,219,129	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).			13,568	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)			0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)			0	56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).			0	57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			16,651,729	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			16,651,729	61.00
62.00	Deductibles billed to program beneficiaries			1,588,676	62.00
63.00	Coinurance billed to program beneficiaries			9,176	63.00
64.00	Allowable bad debts (see instructions)			74,339	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			48,320	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			48,073	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			15,102,197	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			-3,411	70.00
70.92	Bundled Model 1 discount amount			0	70.92
70.93	HVBP incentive payment (see instructions)			26,831	70.93
70.94	Hospital readmissions reduction adjustment (see instructions)			0	70.94
70.95	Recovery of Accelerated Depreciation			0	70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/27/2014 12:14 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	On/After October 1 2.00	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		15,125,617		71.00
71.01	Sequestration adjustment (see instructions)		228,397		71.01
72.00	Interim payments		14,843,138		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		54,082		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		377,488		75.00
TO BE COMPLETED BY CONTRACTOR					
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the Time Value of Money		0.00		94.00
95.00	Time Value of Money for operating expenses(see instructions)		0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)		0		96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/27/2014 12:14 pm
		Title XVII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,336	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		8,345,463	2.00
3.00	PPS payments		6,852,756	3.00
4.00	Outlier payment (see instructions)		11,197	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)		2,336	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		15,591	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)		15,591	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		15,591	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		13,255	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)		2,336	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)		6,863,953	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		366	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,628,455	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)		5,237,468	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		4,943	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)		5,242,411	30.00
31.00	Primary payer payments		2,144	31.00
32.00	Subtotal (line 30 minus line 31)		5,240,267	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		122,681	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		79,743	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		73,787	36.00
37.00	Subtotal (see instructions)		5,320,010	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-139	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)		5,320,149	40.00
40.01	Sequestration adjustment (see instructions)		80,334	40.01
41.00	Interim payments		5,150,809	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		89,006	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150057

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

Worksheet E-1
Part I
Date/Time Prepared:
5/27/2014 12:14 pm

Title XVIII

Hospital

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		14,901,538		5,204,009	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	07/13/2013	58,400	07/13/2013	53,200	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)		-58,400		-53,200	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)		14,843,138		5,150,809	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		54,082		89,006	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		14,897,220		5,239,815	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: 150057

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

Worksheet E-1
Part II
Date/Time Prepared:
5/27/2014 12:14 pm

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	3,420	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	5,276	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2	1,307	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	10,534	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	301,844,950	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	15,525,153	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)	808,414	8.00
9.00	Sequestration adjustment amount (see instructions)	16,168	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	792,246	10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30.00	Initial/interim HIT payment adjustment (see instructions)	702,077	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)	90,169	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part VII Date/Time Prepared: 5/27/2014 12:14 pm	
		Title XIX	Hospital	PPS	
		Inpatient	Outpatient		
		1.00	2.00		
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services	0			1.00
2.00	Medical and other services		3,030,922		2.00
3.00	Organ acquisition (certified transplant centers only)	0			3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	3,030,922		4.00
5.00	Inpatient primary payer payments	0			5.00
6.00	Outpatient primary payer payments		0		6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	3,030,922		7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges	0			8.00
9.00	Ancillary service charges	5,203,331	24,831,720		9.00
10.00	Organ acquisition charges, net of revenue	0			10.00
11.00	Incentive from target amount computation	0			11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	5,203,331	24,831,720		12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0		13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	0		14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000		15.00
16.00	Total customary charges (see instructions)	5,203,331	24,831,720		16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	5,203,331	21,800,798		17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0		18.00
19.00	Interns and Residents (see instructions)	0	0		19.00
20.00	Cost of Teaching Physicians (see instructions)	0	0		20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	3,030,922		21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments	0	0		22.00
23.00	Outlier payments	0	0		23.00
24.00	Program capital payments	0			24.00
25.00	Capital exception payments (see instructions)	0			25.00
26.00	Routine and Ancillary service other pass through costs	0	0		26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0		27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	3,030,922		29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)	0	0		30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	3,030,922		31.00
32.00	Deductibles	0	0		32.00
33.00	Coinurance	0	0		33.00
34.00	Allowable bad debts (see instructions)	0	0		34.00
35.00	Utilization review	0			35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	3,030,922		36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0		37.00
38.00	Subtotal (line 36 ± line 37)	0	3,030,922		38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0			39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	3,030,922		40.00
41.00	Interim payments	0	3,030,922		41.00
42.00	Balance due provider/program (line 40 minus 41)	0	0		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	0		43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet E-4 Date/Time Prepared: 5/27/2014 12:14 pm	
		Title VIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.75	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			0.75	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.46	6.00
7.00	Enter the lesser of line 5 or line 6			0.46	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.08	0.38	0.46	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.08	0.38	0.46	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
11.00	Total weighted FTE count	0.08	0.38		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.34	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.32	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.25	0.13		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
17.00	Adjusted rolling average FTE count	0.25	0.13		17.00
18.00	Per resident amount	80,201.92	80,201.92		18.00
19.00	Approved amount for resident costs	20,050	10,426	30,476	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			30,476	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	5,276	1,307		26.00
27.00	Total Inpatient Days (see instructions)	10,534	10,534		27.00
28.00	Ratio of inpatient days to total inpatient days	0.500854	0.124074		28.00
29.00	Program direct GME amount	15,264	3,781		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		534		30.00
31.00	Net Program direct GME amount			18,511	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet E-4 Date/Time Prepared: 5/27/2014 12:14 pm
		Title XVIII	Hospital	PPS
				1.00
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)			0 32.00
33.00	Renal dialysis and home dialysis total charges (Worksheet C, Part I, column 8, sum of lines 74 and 94)			0 33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000 34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0 35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0 36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)			22,907,939 37.00
38.00	Organ acquisition costs (Worksheet D-4, Part III, column 1, line 69)			0 38.00
39.00	Cost of teaching physicians (Worksheet D-5, Part II, column 3, line 20)			0 39.00
40.00	Primary payer payments (see instructions)			0 40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			22,907,939 41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)			8,347,799 42.00
43.00	Primary payer payments (see instructions)			2,144 43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			8,345,655 44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			31,253,594 45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.732970 46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.267030 47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)			18,511 48.00
49.00	Part A Medicare GME payment (line 46 x 48) (Title XVIII only) (see instructions)			13,568 49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			4,943 50.00

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

Provider CCN: 150057

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

Worksheet G

Date/Time Prepared:
5/27/2014 12:14 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	4,885,116	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	36,823,585	0	0	0	4.00
5.00	Other receivable	807,498	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-26,377,966	0	0	0	6.00
7.00	Inventory	2,907,536	0	0	0	7.00
8.00	Prepaid expenses	383,452	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	285,012	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	19,714,233	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	1,432,719	0	0	0	13.00
14.00	Accumulated depreciation	-551,347	0	0	0	14.00
15.00	Buildings	80,974,988	0	0	0	15.00
16.00	Accumulated depreciation	-31,161,275	0	0	0	16.00
17.00	Leasehold improvements	592,542	0	0	0	17.00
18.00	Accumulated depreciation	-228,026	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	23,384,057	0	0	0	23.00
24.00	Accumulated depreciation	-8,998,791	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)	65,444,867	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,881,590	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,881,590	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	87,040,690	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	4,213,758	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,530,357	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	-32,895	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,711,220	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	-940,529	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-940,529	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,770,691	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	81,269,999				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)	81,269,999	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	87,040,690	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150057

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

Worksheet G-1

Date/Time Prepared:
5/27/2014 12:14 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		85,638,512			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		23,436,288				2.00
3.00	Total (sum of line 1 and line 2)		109,074,800			0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0			0	10.00
11.00	Subtotal (line 3 plus line 10)		109,074,800			0	11.00
12.00	Deductions- FUND EQUITY CHANGES	27,798,785		0		0	12.00
13.00	PBC OUT OF BALANCE	6,016		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		27,804,801			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		81,269,999			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- FUND EQUITY CHANGES		0				12.00
13.00	PBC OUT OF BALANCE		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: 150057

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/27/2014 12:14 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	20,250,223		20,250,223	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)	20,250,223		20,250,223	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT	0		0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	20,250,223		20,250,223	17.00
18.00	Ancillary services	103,714,593	116,981,327	220,695,920	18.00
19.00	Outpatient services	4,578,531	56,320,276	60,898,807	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER	5,596	6,462,949	6,468,545	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	128,548,943	179,764,552	308,313,495	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		78,061,906		29.00
30.00	ADD - SHARED SERVICES ALLOCATION	15,187,043			30.00
31.00	ADDITIONAL SHARED SERVICES	4,158,474			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)		19,345,517		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)		97,407,423		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150057

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

Worksheet G-3

Date/Time Prepared:
5/27/2014 12:14 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	308,313,495	1.00
2.00	Less contractual allowances and discounts on patients' accounts	193,805,493	2.00
3.00	Net patient revenues (line 1 minus line 2)	114,508,002	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	97,407,423	4.00
5.00	Net income from service to patients (line 3 minus line 4)	17,100,579	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	140,233	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	189,257	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	274,415	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	146,747	20.00
21.00	Rental of vending machines	9,692	21.00
22.00	Rental of hospital space	1,333,115	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER - IDENTIFIED ON TRIAL BALANCE	4,242,250	24.00
25.00	Total other income (sum of lines 6-24)	6,335,709	25.00
26.00	Total (line 5 plus line 25)	23,436,288	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)	23,436,288	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150057	Period: From 01/01/2013 To 12/31/2013	Worksheet L Parts I-III Date/Time Prepared: 5/27/2014 12:14 pm
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,209,103	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		5,552	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)		28.86	3.00
4.00	Number of interns & residents (see instructions)		0.38	4.00
5.00	Indirect medical education percentage (see instructions)		0.37	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)		4,474	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		0	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		1,219,129	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00