

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: 263303	Period: From 07/01/2012 To 06/30/2013	Worksheet S Parts I-III Date/Time Prepared: 11/21/2013 10:02 am
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**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: 11/21/2013 Time: 10:02 am
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 RANKEN JORDAN ( 263303 ) for the cost reporting period beginning 07/01/2012 and ending 06/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	5,629	10	0	3,890,435	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	5,629	10	0	3,890,435	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: 263303	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 11/21/2013 9:57 am
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1.00	Hospital and Hospital Health Care Complex Address:		2.00	3.00	4.00
1.00	Street: 11365 DORSETT ROAD	PO Box:	2.00	3.00	4.00
2.00	City: MARYLAND HEIGHTS	State: MO	Zip Code: 63043-	County: SAINT LOUIS	

	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	RANKEN JORDAN	263303	41180	7	07/31/2002	N	T	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
20.00	Cost Reporting Period (mm/dd/yyyy)	1.00	2.00	20.00
21.00	Type of Control (see instructions)	07/01/2012	06/30/2013	21.00
		2		

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
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	25.00

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

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		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00
		V 1.00	XVIII 2.00	XIX 3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN and general surgery) added as a result of section 5503. (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06
		Program Name 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

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	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
	1.00	2.00	3.00	4.00		
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.		0.00	0.00	61.20	
				1.00		
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)			0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)			0.00	62.01	
<u>Teaching Hospitals that Claim Residents in Non-Provider Settings</u>						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)			N	63.00	
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
<u>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.</u>						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovi der Site	Unweighted 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
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
<u>Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010</u>						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
<b>Inpatient Psychiatric Facility PPS</b>							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			N	N	0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			N	N	0	76.00
					1.00		
<b>Long Term Care Hospital PPS</b>							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N		80.00
<b>TEFRA Providers</b>							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00
					V		XIX
					1.00		2.00
<b>Title V and XIX Services</b>							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	97.00
<b>Rural Providers</b>							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			N			106.00

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		V	XIX		
		1.00	2.00		
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
		1.00	2.00	3.00	
<b>Miscellaneous Cost Reporting Information</b>					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	194,250	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		
119.00	DO NOT USE THIS LINE				
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N	
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N		
<b>Transplant Center Information</b>					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				
<b>All Providers</b>					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y		

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1.00		2.00		3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00
142.00	Street:	PO Box:				142.00
143.00	City:	State:		Zip Code:		143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N	145.00

		1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00

		Part A 1.00	Part B 2.00	Title V 3.00	Title XIX 4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

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

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

		1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	N	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)		0.00
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)		0.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 263303	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part II Date/Time Prepared: 11/21/2013 9:57 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	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.	Y			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			N	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	11/19/2013	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00



HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 263303

Period:  
From 07/01/2012  
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Worksheet S-2  
Part II  
Date/Time Prepared:  
11/21/2013 9:57 am

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN		WELLEN	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.	314-231-5544		KWELLEN@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet S-2  
Part II  
Date/Time Prepared:  
11/21/2013 9:57 am

		Part B	
		Date	
		4.00	
<b>PS&amp;R Data</b>			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	11/19/2013	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
<b>Cost Report Preparer Contact Information</b>			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR	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: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/21/2013 9:57 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	34	12,410	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)		34	12,410	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		34	12,410	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	99.00				0	25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		34				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)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet S-3  
Part I  
Date/Time Prepared:  
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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)	10	4,437	10,360			1.00
2.00 HMO and other (see instructions)	0	1,829				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)	10	4,437	10,360			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)	10	4,437	10,360	0.00	237.12	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	0	0	0	0.00	0.00	25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	237.12	27.00
28.00 Observation Bed Days		0	0			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/21/2013 9:57 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	1	99	280	1.00
2.00 HMO and other (see instructions)				0			2.00
3.00 HMO IPF Subprovider							3.00
4.00 HMO IRF Subprovider							4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0		1	99	280	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	0.00						25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
33.00 LTCH non-covered days							33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 263303	Period: From 07/01/2012 To 06/30/2013	Worksheet S-10 Date/Time Prepared: 11/21/2013 9:57 am
				1.00
<b>Uncompensated and indigent care cost computation</b>				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.807282	1.00
<b>Medicaid (see instructions for each line)</b>				
2.00	Net revenue from Medicaid		11,121,822	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		7,439,428	5.00
6.00	Medicaid charges		22,359,896	6.00
7.00	Medicaid cost (line 1 times line 6)		18,050,742	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)		0	8.00
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>				
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
<b>Other state or local government indigent care program (see instructions for each line)</b>				
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
<b>Uncompensated care (see instructions for each line)</b>				
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)		0	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	142,200	0	142,200
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	114,796	0	114,796
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	114,796	0	114,796
				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)		304,052	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		0	27.00
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)		304,052	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		245,456	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		360,252	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		360,252	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet A

Date/Time Prepared:  
11/21/2013 9:57 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		1,378,933	1,378,933	106,895	1,485,828	1.00
2.00	00200		0	0	834,925	834,925	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	322,882	3,519,852	3,842,734	0	3,842,734	4.00
5.00	00500	2,679,016	4,656,851	7,335,867	106,582	7,442,449	5.00
6.00	00600	385,674	612,754	998,428	0	998,428	6.00
10.00	01000	221,976	82,901	304,877	-13,004	291,873	10.00
13.00	01300	575,285	7,605	582,890	645,520	1,228,410	13.00
17.00	01700	178,517	77,378	255,895	0	255,895	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	6,335,989	834,342	7,170,331	-1,032,432	6,137,899	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	0	72,154	72,154	0	72,154	54.00
60.00	06000	0	57,883	57,883	0	57,883	60.00
65.00	06500	766,799	393,421	1,160,220	0	1,160,220	65.00
66.00	06600	2,399,720	118,247	2,517,967	-155,074	2,362,893	66.00
69.00	06900	0	98,553	98,553	0	98,553	69.00
71.00	07100	197,624	1,326	198,950	386,912	585,862	71.00
73.00	07300	480,910	759,558	1,240,468	0	1,240,468	73.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	09900	0	0	0	0	0	99.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300		880,324	880,324	-880,324	0	113.00
118.00		14,544,392	13,552,082	28,096,474	0	28,096,474	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
200.00		14,544,392	13,552,082	28,096,474	0	28,096,474	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet A  
Date/Time Prepared:  
11/21/2013 9:57 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	388,014	1,873,842	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	834,925	2.00
3.00	00300	OTHER CAP RELATED COST	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-390,421	3,452,313	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-771,578	6,670,871	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	998,428	6.00
10.00	01000	DIETARY	0	291,873	10.00
13.00	01300	NURSING ADMINISTRATION	0	1,228,410	13.00
17.00	01700	SOCIAL SERVICE	0	255,895	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-2,089,236	4,048,663	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	72,154	54.00
60.00	06000	LABORATORY	0	57,883	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,160,220	65.00
66.00	06600	PHYSICAL THERAPY	0	2,362,893	66.00
69.00	06900	ELECTROCARDIOLOGY	0	98,553	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	585,862	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,240,468	73.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.00	09900	CMHC	0	0	99.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,863,221	25,233,253	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
200.00		TOTAL (SUM OF LINES 118-199)	-2,863,221	25,233,253	200.00



RECLASSIFICATIONS

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet A-6

Date/Time Prepared:  
11/21/2013 9:57 am

		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
<b>A - TO RECLASS INTEREST EXPENSE</b>						
1.00	CAP REL COSTS-BLDG & FIXT		1.00	0	880,324	1.00
	TOTALS			0	880,324	
<b>B - TO RECLASS NURSING SALARIES</b>						
1.00	NURSING ADMINISTRATION		13.00	645,520	0	1.00
	TOTALS			645,520	0	
<b>C - TO RECLASS MEDICAL SUPPLY EXPENSE</b>						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00	0	386,912	1.00
	TOTALS			0	386,912	
<b>D - TO RECLASS DEPRECIATION EXPENSE</b>						
1.00	CAP REL COSTS-MVBLE EQUIP		2.00	0	815,792	1.00
	TOTALS			0	815,792	
<b>E - TO RECLASS INSURANCE EXPENSE</b>						
1.00	OTHER CAP RELATED COST		3.00	0	54,635	1.00
	TOTALS			0	54,635	
<b>F - TO RECLASS PROPERTY TAXES</b>						
1.00	OTHER CAP RELATED COST		3.00	0	6,861	1.00
	TOTALS			0	6,861	
<b>G - TO RECLASS RECEPTIONIST/SECURITY SAL</b>						
1.00	ADMINISTRATIVE & GENERAL		5.00	168,078	0	1.00
	TOTALS			168,078	0	
<b>H - TO RECLASS DIETARY CONSULTANTS</b>						
1.00	PHYSICAL THERAPY		66.00	13,004	0	1.00
	TOTALS			13,004	0	
500.00	Grand Total: Increases			826,602	2,144,524	500.00

RECLASSIFICATIONS

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet A-6

Date/Time Prepared:  
11/21/2013 9:57 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	880,324	11		1.00
	TOTALS		0	880,324			
	B - TO RECLASS NURSING SALARIES						
1.00	ADULTS & PEDIATRICS	30.00	645,520	0	0		1.00
	TOTALS		645,520	0			
	C - TO RECLASS MEDICAL SUPPLY EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	0	386,912	0		1.00
	TOTALS		0	386,912			
	D - TO RECLASS DEPRECIATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	815,792	9		1.00
	TOTALS		0	815,792			
	E - TO RECLASS INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	54,635	5		1.00
	TOTALS		0	54,635			
	F - TO RECLASS PROPERTY TAXES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,861	6		1.00
	TOTALS		0	6,861			
	G - TO RECLASS RECEPTIONIST/SECURITY SAL						
1.00	PHYSICAL THERAPY	66.00	168,078	0	0		1.00
	TOTALS		168,078	0			
	H - TO RECLASS DIETARY CONSULTANTS						
1.00	DIETARY	10.00	13,004	0	0		1.00
	TOTALS		13,004	0			
500.00	Grand Total: Decreases		826,602	2,144,524			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet A-7  
Part I  
Date/Time Prepared:  
11/21/2013 9:57 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	2,359,177	0	0	0	1.00
2.00	Land Improvements	1,060,527	0	0	0	2.00
3.00	Buildings and Fixtures	20,480,597	407,388	0	407,388	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	4,476,748	756,915	0	756,915	6.00
7.00	HIT designated Assets	2,871,912	2,875,340	0	2,875,340	7.00
8.00	Subtotal (sum of lines 1-7)	31,248,961	4,039,643	0	4,039,643	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	31,248,961	4,039,643	0	4,039,643	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	2,359,177	0			1.00
2.00	Land Improvements	1,060,527	0			2.00
3.00	Buildings and Fixtures	20,887,985	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	5,230,724	0			6.00
7.00	HIT designated Assets	5,747,252	0			7.00
8.00	Subtotal (sum of lines 1-7)	35,285,665	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	35,285,665	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet A-7  
Part II  
Date/Time Prepared:  
11/21/2013 9:57 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	1,371,691	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,371,691	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	7,242	1,378,933				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	7,242	1,378,933				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet A-7  
Part III  
Date/Time Prepared:  
11/21/2013 9:57 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	24,307,689	0	24,307,689	0.688883	37,637	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	10,977,976	0	10,977,976	0.311117	16,998	2.00
3.00	Total (sum of lines 1-2)	35,285,665	0	35,285,665	1.000000	54,635	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	4,726	0	42,363	555,899	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,135	0	19,133	815,792	0	2.00
3.00	Total (sum of lines 1-2)	6,861	0	61,496	1,371,691	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	880,324	37,637	4,726	395,256	1,873,842	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	16,998	2,135	0	834,925	2.00
3.00	Total (sum of lines 1-2)	880,324	54,635	6,861	395,256	2,708,767	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet A-8

Date/Time Prepared:  
11/21/2013 9:57 am

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 #		
			3.00	4.00		
		1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0 1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0 2.00
3.00 Investment income - other (chapter 2)			0		0.00	0 3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0 4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0 5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0 7.00
8.00 Television and radio service (chapter 21)			0		0.00	0 8.00
9.00 Parking lot (chapter 21)			0		0.00	0 9.00
10.00 Provider-based physician adjustment	A-8-2	-2,079,236				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		0			0 12.00
13.00 Laundry and linen service			0		0.00	0 13.00
14.00 Cafeteria-employees and guests			0		0.00	0 14.00
15.00 Rental of quarters to employee and others			0		0.00	0 15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0 16.00
17.00 Sale of drugs to other than patients			0		0.00	0 17.00
18.00 Sale of medical records and abstracts	B	-4,598		ADMINISTRATIVE & GENERAL	5.00	0 18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0 19.00
20.00 Vending machines			0		0.00	0 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0 26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0 27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00	28.00
29.00 Physicians' assistant			0		0.00	0 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00	30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00	30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0 32.00
33.00 LOBBYING EXPENSE	A	-50,240		ADMINISTRATIVE & GENERAL	5.00	0 33.00
33.01 ADVERTISING EXPENSE	A	-151,497		ADMINISTRATIVE & GENERAL	5.00	0 33.01

Provider CCN: 263303

Period:  
 From 07/01/2012  
 To 06/30/2013

Worksheet A-8

Date/Time Prepared:  
 11/21/2013 9:57 am

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		3.00	4.00
33.02	MARKETING SALARY EXPENSE	A	-183,712	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MARKETING BENEFIT EXPENSE	A	-44,448	EMPLOYEE BENEFITS	4.00	0	33.03
33.04	MARKETING OTHER EXPENSE	A	-70,529	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	DEVELOPMENT SALARY EXPENSE	A	-185,593	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	DEVELOPMENT BENEFIT EXPENSE	A	-42,438	EMPLOYEE BENEFITS	4.00	0	33.06
33.07	DEVELOPMENT OTHER EXPENSE	A	-83,815	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	MISCELLANEOUS REVENUE	B	-5,122	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	LOSS ON EARLY EXTINGUISHMENT OF DEBT	A	388,014	CAP REL COSTS-BLDG & FIXT	1.00	14	33.09
33.10	COUNTRY CLUB DUES	A	-7,049	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	ALCOHOL EXPENSES	A	-105	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	HEALTH LINK ADMINISTRATIVE EXPENSES	A	18,474	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	DONATION EXPENSE	A	-47,147	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	PROVIDER BASED PHYSICIAN BENEFITS	A	-303,535	EMPLOYEE BENEFITS	4.00	0	33.14
33.15	GIFT IN KIND	A	-645	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	PHYSICIAN RECRUITMENT	A	-10,000	ADULTS & PEDIATRICS	30.00	0	33.16
33.17			0		0.00	0	33.17
33.18			0		0.00	0	33.18
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,863,221				50.00

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

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet A-8-1

Date/Time Prepared:  
11/21/2013 9:57 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	101,555	101,555	1.00
2.00	6.00	MAINTENANCE & REPAIRS	12,478	12,478	2.00
3.00	0.00		0	0	3.00
4.00	0.00		0	0	4.00
5.00	0	0	114,033	114,033	5.00

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

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00
B. 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	D	THOMAS MI NOGUE	0.00	THOMPSON COBURN	0.00	6.00
7.00	D	GEORGE EDINGER	0.00	C&R MECHANICAL	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: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet A-8-1

Date/Time Prepared:  
11/21/2013 9:57 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	0	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	0	0		5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
<b>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>			

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

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

6.00	LAW FIRM		6.00
7.00	HVAC COMPANY		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: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet A-8-2

Date/Time Prepared:  
11/21/2013 9:57 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	2,116,986	2,057,794	59,192	140,600	520	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,116,986	2,057,794	59,192		520	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	35,150	1,758	12,708	355	80,294	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			35,150	1,758	12,708	355	80,294	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	2,245	37,750	21,442	2,079,236		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			2,245	37,750	21,442	2,079,236		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet B  
Part I  
Date/Time Prepared:  
11/21/2013 9:57 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,873,842	1,873,842			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	834,925		834,925		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	3,452,313	0	0	3,452,313	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	6,670,871	306,831	136,714	719,595	5.00
6.00 00600	MAINTENANCE & REPAIRS	998,428	307,639	137,074	112,007	6.00
10.00 01000	DIETARY	291,873	50,387	22,451	60,689	10.00
13.00 01300	NURSING ADMINISTRATION	1,228,410	122,502	54,583	354,544	13.00
17.00 01700	SOCIAL SERVICE	255,895	47,963	21,371	51,845	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	4,048,663	883,473	393,648	1,081,996	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00 05400	RADIOLOGY - DIAGNOSTIC	72,154	0	0	0	54.00
60.00 06000	LABORATORY	57,883	0	0	0	60.00
65.00 06500	RESPIRATORY THERAPY	1,160,220	0	0	222,692	65.00
66.00 06600	PHYSICAL THERAPY	2,362,893	155,047	69,084	651,886	66.00
69.00 06900	ELECTROCARDIOLOGY	98,553	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	585,862	0	0	57,394	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,240,468	0	0	139,665	73.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00 09900	CMHC	0	0	0	0	99.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00 118.00	SUBTOTALS (SUM OF LINES 1-117)	25,233,253	1,873,842	834,925	3,452,313	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
200.00 200.00	Cross Foot Adjustments					200.00
201.00 201.00	Negative Cost Centers		0	0	0	201.00
202.00 202.00	TOTAL (sum lines 118-201)	25,233,253	1,873,842	834,925	3,452,313	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet B  
Part I  
Date/Time Prepared:  
11/21/2013 9:57 am

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	DIETARY	NURSING ADMINISTRATION	SOCIAL SERVICE		
		5.00	6.00	10.00	13.00	17.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION						13.00
17.00	01700	SOCIAL SERVICE						17.00
		7,834,011						
		700,205	2,255,353					
		191,536	90,236	707,172				
		792,458	219,384		2,771,881			
		169,778	85,894		0	632,746		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS						30.00
		2,885,106	1,582,171	707,172	2,737,043	632,746		
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400	RADIOLOGY - DIAGNOSTIC						54.00
60.00	06000	LABORATORY						60.00
65.00	06500	RESPIRATORY THERAPY						65.00
66.00	06600	PHYSICAL THERAPY						66.00
69.00	06900	ELECTROCARDIOLOGY						69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS						71.00
73.00	07300	DRUGS CHARGED TO PATIENTS						73.00
		32,487	0	0	0	0		
		26,062	0	0	0	0		
		622,656	0	0	0	0		
		1,458,319	277,668	0	34,838	0		
		44,373	0	0	0	0		
		289,626	0	0	0	0		
		621,405	0	0	0	0		
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.00	09900	CMHC						99.00
		0	0	0	0	0		
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)						118.00
		7,834,011	2,255,353	707,172	2,771,881	632,746		
<b>NONREIMBURSABLE COST CENTERS</b>								
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		TOTAL (sum lines 118-201)						202.00
		0	0	0	0	0		
		7,834,011	2,255,353	707,172	2,771,881	632,746		

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet B  
Part I  
Date/Time Prepared:  
11/21/2013 9:57 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
10.00	01000				10.00
13.00	01300				13.00
17.00	01700				17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	14,952,018	0	14,952,018	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
54.00	05400	104,641	0	104,641	54.00
60.00	06000	83,945	0	83,945	60.00
65.00	06500	2,005,568	0	2,005,568	65.00
66.00	06600	5,009,735	0	5,009,735	66.00
69.00	06900	142,926	0	142,926	69.00
71.00	07100	932,882	0	932,882	71.00
73.00	07300	2,001,538	0	2,001,538	73.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.00	09900	0	0	0	99.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300				113.00
118.00		25,233,253	0	25,233,253	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		25,233,253	0	25,233,253	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet B  
Part II  
Date/Time Prepared:  
11/21/2013 9:57 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	55,478	306,831	136,714	499,023	5.00
6.00 00600	MAINTENANCE & REPAIRS	4,344	307,639	137,074	449,057	6.00
10.00 01000	DIETARY	0	50,387	22,451	72,838	10.00
13.00 01300	NURSING ADMINISTRATION	0	122,502	54,583	177,085	13.00
17.00 01700	SOCIAL SERVICE	0	47,963	21,371	69,334	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	883,473	393,648	1,277,121	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00 05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	0	0	0	0	60.00
65.00 06500	RESPIRATORY THERAPY	121,127	0	0	121,127	65.00
66.00 06600	PHYSICAL THERAPY	0	155,047	69,084	224,131	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	211,300	0	0	211,300	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00 09900	CMHC	0	0	0	0	99.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	392,249	1,873,842	834,925	3,101,016	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
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)	392,249	1,873,842	834,925	3,101,016	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet B  
Part II  
Date/Time Prepared:  
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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	DIETARY	NURSING ADMINISTRATION	SOCIAL SERVICE	
		5.00	6.00	10.00	13.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	499,023					5.00
6.00	00600	44,603	493,660				6.00
10.00	01000	12,201	19,751	104,790			10.00
13.00	01300	50,480	48,020		275,585		13.00
17.00	01700	10,815	18,801			98,950	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	183,777	346,311	104,790	272,121	98,950	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	2,069	0	0	0	0	54.00
60.00	06000	1,660	0	0	0	0	60.00
65.00	06500	39,663	0	0	0	0	65.00
66.00	06600	92,895	60,777	0	3,464	0	66.00
69.00	06900	2,827	0	0	0	0	69.00
71.00	07100	18,449	0	0	0	0	71.00
73.00	07300	39,584	0	0	0	0	73.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	09900	0	0	0	0	0	99.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		499,023	493,660	104,790	275,585	98,950	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		499,023	493,660	104,790	275,585	98,950	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet B  
Part II  
Date/Time Prepared:  
11/21/2013 9:57 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
10.00	01000				10.00
13.00	01300				13.00
17.00	01700				17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	2,283,070	0	2,283,070	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
54.00	05400	2,069	0	2,069	54.00
60.00	06000	1,660	0	1,660	60.00
65.00	06500	160,790	0	160,790	65.00
66.00	06600	381,267	0	381,267	66.00
69.00	06900	2,827	0	2,827	69.00
71.00	07100	229,749	0	229,749	71.00
73.00	07300	39,584	0	39,584	73.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.00	09900	0	0	0	99.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300				113.00
118.00		3,101,016	0	3,101,016	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		3,101,016	0	3,101,016	202.00



COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet B-1

Date/Time Prepared:  
11/21/2013 9:57 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	60,283				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		60,283			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	11,887,413		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	9,871	9,871	2,477,789	-7,834,011	5.00
6.00 00600	MAINTENANCE & REPAIRS	9,897	9,897	385,674	0	6.00
10.00 01000	DIETARY	1,621	1,621	208,972	0	10.00
13.00 01300	NURSING ADMINISTRATION	3,941	3,941	1,220,805	0	13.00
17.00 01700	SOCIAL SERVICE	1,543	1,543	178,517	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	28,422	28,422	3,725,677	0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00 05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	0	0	0	0	60.00
65.00 06500	RESPIRATORY THERAPY	0	0	766,799	0	65.00
66.00 06600	PHYSICAL THERAPY	4,988	4,988	2,244,646	0	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	197,624	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	480,910	0	73.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00 09900	CMHC	0	0	0	0	99.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	60,283	60,283	11,887,413	-7,834,011	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,873,842	834,925	3,452,313	7,834,011	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	31.084087	13.850090	0.290418	0.450250	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0	499,023	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000	0.028681	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet B-1

Date/Time Prepared:  
11/21/2013 9:57 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	SOCIAL SERVICE (TIME SPENT)		
		6.00	10.00	13.00	17.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	40,515					6.00
10.00	01000	1,621	31,080				10.00
13.00	01300	3,941	0	164,460			13.00
17.00	01700	1,543	0	0	7,911		17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	28,422	31,080	162,393	7,911		30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	0	0	0	0		54.00
60.00	06000	0	0	0	0		60.00
65.00	06500	0	0	0	0		65.00
66.00	06600	4,988	0	2,067	0		66.00
69.00	06900	0	0	0	0		69.00
71.00	07100	0	0	0	0		71.00
73.00	07300	0	0	0	0		73.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	09900	0	0	0	0		99.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		40,515	31,080	164,460	7,911		118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
200.00							200.00
201.00							201.00
202.00		2,255,353	707,172	2,771,881	632,746		202.00
203.00		55.667111	22.753282	16.854439	79.983062		203.00
204.00		493,660	104,790	275,585	98,950		204.00
205.00		12.184623	3.371622	1.675696	12.507900		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet C  
Part I  
Date/Time Prepared:  
11/21/2013 9:57 am

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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	14,952,018		14,952,018	0	0 30.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400 RADIOLOGY - DIAGNOSTIC	104,641		104,641	0	0 54.00	
60.00	06000 LABORATORY	83,945		83,945	0	0 60.00	
65.00	06500 RESPIRATORY THERAPY	2,005,568	0	2,005,568	0	0 65.00	
66.00	06600 PHYSICAL THERAPY	5,009,735	0	5,009,735	0	0 66.00	
69.00	06900 ELECTROCARDIOLOGY	142,926		142,926	0	0 69.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	932,882		932,882	0	0 71.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	2,001,538		2,001,538	0	0 73.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	09900 CMHC	0		0		0 99.00	
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						
200.00	Subtotal (see instructions)	25,233,253	0	25,233,253	0	0 200.00	
201.00	Less Observation Beds	0		0		0 201.00	
202.00	Total (see instructions)	25,233,253	0	25,233,253	0	0 202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet C  
Part I  
Date/Time Prepared:  
11/21/2013 9:57 am

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	18,648,000		18,648,000			30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY - DIAGNOSTIC	114,902	135	115,037	0.909629	0.909629	54.00
60.00	06000 LABORATORY	68,006	0	68,006	1.234376	1.234376	60.00
65.00	06500 RESPIRATORY THERAPY	7,036,366	0	7,036,366	0.285029	0.285029	65.00
66.00	06600 PHYSICAL THERAPY	1,998,844	1,605,581	3,604,425	1.389885	1.389885	66.00
69.00	06900 ELECTROCARDIOLOGY	152,171	862	153,033	0.933955	0.933955	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	501,231	0	501,231	1.861182	1.861182	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,129,872	1,060	1,130,932	1.769813	1.769813	73.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900 CMHC	0	0	0			99.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	29,649,392	1,607,638	31,257,030			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	29,649,392	1,607,638	31,257,030			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet C  
Part I  
Date/Time Prepared:  
11/21/2013 9:57 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Tefra
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
30.00	03000 ADULTS & PEDIATRICS				30.00
	ANCILLARY SERVICE COST CENTERS				
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
	OTHER REIMBURSABLE COST CENTERS				
99.00	09900 CMHC				99.00
	SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet C  
Part I  
Date/Time Prepared:  
11/21/2013 9:57 am

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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	14,952,018		14,952,018	0	0 30.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400 RADIOLOGY - DIAGNOSTIC	104,641		104,641	0	0 54.00	
60.00	06000 LABORATORY	83,945		83,945	0	0 60.00	
65.00	06500 RESPIRATORY THERAPY	2,005,568	0	2,005,568	0	0 65.00	
66.00	06600 PHYSICAL THERAPY	5,009,735	0	5,009,735	0	0 66.00	
69.00	06900 ELECTROCARDIOLOGY	142,926		142,926	0	0 69.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	932,882		932,882	0	0 71.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	2,001,538		2,001,538	0	0 73.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	09900 CMHC	0		0		0 99.00	
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						
200.00	Subtotal (see instructions)	25,233,253	0	25,233,253	0	0 200.00	
201.00	Less Observation Beds	0		0		0 201.00	
202.00	Total (see instructions)	25,233,253	0	25,233,253	0	0 202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet C  
Part I  
Date/Time Prepared:  
11/21/2013 9:57 am

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	18,648,000		18,648,000			30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY - DIAGNOSTIC	114,902	135	115,037	0.909629	0.000000	54.00
60.00	06000 LABORATORY	68,006	0	68,006	1.234376	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	7,036,366	0	7,036,366	0.285029	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	1,998,844	1,605,581	3,604,425	1.389885	0.000000	66.00
69.00	06900 ELECTROCARDIOLOGY	152,171	862	153,033	0.933955	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	501,231	0	501,231	1.861182	0.000000	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,129,872	1,060	1,130,932	1.769813	0.000000	73.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900 CMHC	0	0	0			99.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	29,649,392	1,607,638	31,257,030			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	29,649,392	1,607,638	31,257,030			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet C  
Part I  
Date/Time Prepared:  
11/21/2013 9:57 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OTHER REIMBURSABLE COST CENTERS					
99.00	09900 CMHC				99.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00



APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 263303		Period: From 07/01/2012 To 06/30/2013		Worksheet D Part I Date/Time Prepared: 11/21/2013 9:57 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital Tefra							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,283,070	0	2,283,070	10,360	220.37	30.00
200.00	Total (Lines 30-199)	2,283,070		2,283,070	10,360		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	10	2,204				
200.00	Total (Lines 30-199)	10	2,204				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 263303	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part II Date/Time Prepared: 11/21/2013 9:57 am		
Cost Center Description			Title XVIII	Hospital	Tefra		
	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	RADIOLOGY - DIAGNOSTIC	2,069	115,037	0.017986	0	54.00
60.00	06000	LABORATORY	1,660	68,006	0.024410	2,299	56 60.00
65.00	06500	RESPIRATORY THERAPY	160,790	7,036,366	0.022851	2,717	62 65.00
66.00	06600	PHYSICAL THERAPY	381,267	3,604,425	0.105777	731	77 66.00
69.00	06900	ELECTROCARDIOLOGY	2,827	153,033	0.018473	163	3 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	229,749	501,231	0.458369	186	85 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,584	1,130,932	0.035001	1,763	62 73.00
200.00		Total (lines 50-199)	817,946	12,609,030		7,859	345 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 263303		Period: From 07/01/2012 To 06/30/2013		Worksheet D Part III Date/Time Prepared: 11/21/2013 9:57 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,360	0.00	10	0		30.00
200.00		Total (lines 30-199)	10,360		10	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet D  
Part IV  
Date/Time Prepared:  
11/21/2013 9:57 am

Cost Center Description			Title XVIII				Hospital	
			Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Tefra
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
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: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet D  
Part IV  
Date/Time Prepared:  
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital			
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	115,037	0.000000	0.000000	0	54.00
60.00	06000	LABORATORY	0	68,006	0.000000	0.000000	2,299	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,036,366	0.000000	0.000000	2,717	65.00
66.00	06600	PHYSICAL THERAPY	0	3,604,425	0.000000	0.000000	731	66.00
69.00	06900	ELECTROCARDIOLOGY	0	153,033	0.000000	0.000000	163	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	501,231	0.000000	0.000000	186	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,130,932	0.000000	0.000000	1,763	73.00
200.00		Total (lines 50-199)	0	12,609,030			7,859	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet D  
Part IV  
Date/Time Prepared:  
11/21/2013 9:57 am

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADIOLOGY - DIAGNOSTIC	0	135	0		54.00
60.00	06000 LABORATORY	0	0	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
69.00	06900 ELECTROCARDIOLOGY	0	862	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,060	0		73.00
200.00	Total (lines 50-199)	0	2,057	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet D  
Part V  
Date/Time Prepared:  
11/21/2013 9:57 am

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		
ANCI LLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.909629	135	0	0	123	54.00
60.00	06000	LABORATORY	1.234376	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.285029	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1.389885	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.933955	862	0	0	805	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.861182	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.769813	1,060	0	0	1,876	73.00
200.00		Subtotal (see instructions)		2,057	0	0	2,804	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		2,057	0	0	2,804	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 263303	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part V Date/Time Prepared: 11/21/2013 9:57 am
	Title XVIII	Hospital	Tefra

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					
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00



APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 263303		Period: From 07/01/2012 To 06/30/2013		Worksheet D Part V Date/Time Prepared: 11/21/2013 9:57 am	
			Title XIX		Hospital		Cost	
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	
ANCI LLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.909629	0	0	0	0	54.00
60.00	06000	LABORATORY	1.234376	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.285029	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1.389885	0	156,244	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.933955	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.861182	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.769813	0	0	0	0	73.00
200.00		Subtotal (see instructions)		0	156,244	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	156,244	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet D  
Part V  
Date/Time Prepared:  
11/21/2013 9:57 am

Cost Center Description		Costs		Hospital	Cost
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		6.00	7.00		
ANCI LLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	217,161	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
200.00		Subtotal (see instructions)	217,161	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	217,161	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 263303	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/21/2013 9:57 am
		Title XVIII	Hospital	Tefra
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		10,360	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		10,360	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)		10,360	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)		10	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		14,952,018	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)		14,952,018	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		14,952,018	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,443.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		14,432	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)		14,432	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 263303	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/21/2013 9:57 am
Cost Center Description			Title XVIII	Hospital	Tefra
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
Cost Center Description					
					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				8,246 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				22,678 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)				2,204 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				345 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				2,549 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				20,129 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				1 54.00
55.00	Target amount per discharge				31,909.74 55.00
56.00	Target amount (line 54 x line 55)				31,910 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				11,781 57.00
58.00	Bonus payment (see instructions)				638 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)				23,316 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)				70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				71.00
72.00	Program routine service cost (line 9 x line 71)				72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				76.00
77.00	Program capital-related costs (line 9 x line 76)				77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				80.00
81.00	Inpatient routine service cost per diem limitation				81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				82.00
83.00	Reasonable inpatient routine service costs (see instructions)				83.00
84.00	Program inpatient ancillary services (see instructions)				84.00
85.00	Utilization review - physician compensation (see instructions)				85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)				0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 263303		Period: From 07/01/2012 To 06/30/2013		Worksheet D-1 Date/Time Prepared: 11/21/2013 9:57 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,283,070	14,952,018	0.152693	0	0	90.00
91.00	Nursing School cost	0	14,952,018	0.000000	0	0	91.00
92.00	Allied health cost	0	14,952,018	0.000000	0	0	92.00
93.00	All other Medical Education	0	14,952,018	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 263303	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 11/21/2013 9:57 am
Cost Center Description			Cost	
			1.00	
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		10,360	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		10,360	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)		10,360	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)		4,437	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		14,952,018	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)		14,952,018	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		14,952,018	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,443.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,403,656	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)		6,403,656	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 263303	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/21/2013 9:57 am
Cost Center Description			Title XIX	Hospital	Cost
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
Cost Center Description					
					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				3,470,916
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				9,874,572
PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				0
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				0
52.00	Total Program excludable cost (sum of lines 50 and 51)				0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				0
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				0
55.00	Target amount per discharge				0.00
56.00	Target amount (line 54 x line 55)				0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0
58.00	Bonus payment (see instructions)				0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0
62.00	Relief payment (see instructions)				0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)				70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				71.00
72.00	Program routine service cost (line 9 x line 71)				72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				76.00
77.00	Program capital-related costs (line 9 x line 76)				77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				80.00
81.00	Inpatient routine service cost per diem limitation				81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				82.00
83.00	Reasonable inpatient routine service costs (see instructions)				83.00
84.00	Program inpatient ancillary services (see instructions)				84.00
85.00	Utilization review - physician compensation (see instructions)				85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)				0
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 263303		Period: From 07/01/2012 To 06/30/2013		Worksheet D-1 Date/Time Prepared: 11/21/2013 9:57 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00



INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 263303	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3 Date/Time Prepared: 11/21/2013 9:57 am	
Cost Center Description		Title XVIII	Hospital	Tefra	
		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		18,000		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.909629	0	0	54.00
60.00	06000 LABORATORY	1.234376	2,299	2,838	60.00
65.00	06500 RESPIRATORY THERAPY	0.285029	2,717	774	65.00
66.00	06600 PHYSICAL THERAPY	1.389885	731	1,016	66.00
69.00	06900 ELECTROCARDIOLOGY	0.933955	163	152	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.861182	186	346	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1.769813	1,763	3,120	73.00
200.00	Total (sum of lines 50-94 and 96-98)		7,859	8,246	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)		7,859		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 263303	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3 Date/Time Prepared: 11/21/2013 9:57 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		7,986,600		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.909629	44,830	40,779	54.00
60.00	06000 LABORATORY	1.234376	37,631	46,451	60.00
65.00	06500 RESPIRATORY THERAPY	0.285029	3,586,027	1,022,122	65.00
66.00	06600 PHYSICAL THERAPY	1.389885	573,974	797,758	66.00
69.00	06900 ELECTROCARDIOLOGY	0.933955	83,133	77,642	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.861182	241,527	449,526	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1.769813	585,733	1,036,638	73.00
200.00	Total (sum of lines 50-94 and 96-98)		5,152,855	3,470,916	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)		5,152,855		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 263303	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part B Date/Time Prepared: 11/21/2013 9:57 am
		Title XVII	Hospital	Tefra
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		2,804	2.00
3.00	PPS payments		950	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		950	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		190	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)		760	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		760	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		760	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		760	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		760	40.00
40.01	Sequestration adjustment (see instructions)		4	40.01
41.00	Interim payments		746	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		10	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet E-1  
Part I  
Date/Time Prepared:  
11/21/2013 9:57 am

Title XVIII

Hospital

Tefra

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		17,570		746	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		17,570		746	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		5,746		14	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		23,316		760	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		Provider CCN: 263303	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part I Date/Time Prepared: 11/21/2013 9:57 am
		Title XVIII	Hospital	Tefra
		1.00		
<b>PART I - MEDICARE PART A SERVICES - TEFRA</b>				
1.00	Inpatient hospital services (see instructions)		23,316	1.00
2.00	Organ acquisition		0	2.00
3.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	3.00
4.00	Subtotal (sum of lines 1 thru 3)		23,316	4.00
5.00	Primary payer payments		0	5.00
6.00	Subtotal (line 4 less line 5).		23,316	6.00
7.00	Deductibles		0	7.00
8.00	Subtotal (line 6 minus line 7)		23,316	8.00
9.00	Coinsurance		0	9.00
10.00	Subtotal (line 8 minus line 9)		23,316	10.00
11.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	11.00
12.00	Adjusted reimbursable bad debts (see instructions)		0	12.00
13.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	13.00
14.00	Subtotal (sum of lines 10 and 12)		23,316	14.00
15.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	15.00
16.00	DO NOT USE THIS LINE			16.00
17.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	17.00
17.99	Recovery of Accelerated Depreciation		0	17.99
18.00	Total amount payable to the provider (see instructions)		23,316	18.00
18.01	Sequestration adjustment (see instructions)		117	18.01
19.00	Interim payments		17,570	19.00
20.00	Tentative settlement (for contractor use only)		0	20.00
21.00	Balance due provider/program line 18 minus lines 18.01, 19 and 20		5,629	21.00
22.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	22.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 263303	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part VII Date/Time Prepared: 11/21/2013 9:57 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		9,874,572		1.00
2.00	Medical and other services			217,161	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		9,874,572	217,161	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)		9,874,572	217,161	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		7,986,600		8.00
9.00	Ancillary service charges		5,152,855	156,244	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)		13,139,455	156,244	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		13,139,455	156,244	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		3,264,883	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	60,917	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)		9,874,572	156,244	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		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)		9,874,572	156,244	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	60,917	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		9,874,572	156,244	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)		9,874,572	156,244	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		9,874,572	156,244	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)		9,874,572	156,244	40.00
41.00	Interim payments		5,984,137	156,244	41.00
42.00	Balance due provider/program (line 40 minus 41)		3,890,435	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0	43.00

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

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet G

Date/Time Prepared:  
11/21/2013 9:57 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	323,550	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	4,256,356	0	0	0	4.00
5.00	Other receivable	2,518,402	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	302,053	0	0	0	7.00
8.00	Prepaid expenses	1,203,372	0	0	0	8.00
9.00	Other current assets	1,173,145	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	9,776,878	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	2,359,177	0	0	0	12.00
13.00	Land improvements	1,060,527	0	0	0	13.00
14.00	Accumulated depreciation	-161,503	0	0	0	14.00
15.00	Buildings	20,887,985	0	0	0	15.00
16.00	Accumulated depreciation	-4,223,730	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	10,977,976	0	0	0	23.00
24.00	Accumulated depreciation	-3,334,345	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)	27,566,087	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	24,670,277	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	2,600,141	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	27,270,418	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	64,613,383	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	1,045,725	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,384,257	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	450,000	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	67,412	0	0	0	43.00
44.00	Other current liabilities	607,621	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,555,015	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	18,407,981	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	1,290,084	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	19,698,065	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	24,253,080	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	40,360,303				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)	40,360,303	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	64,613,383	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet G-1

Date/Time Prepared:  
11/21/2013 9:57 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		34,129,751		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		1,083,573			2.00
3.00	Total (sum of line 1 and line 2)		35,213,324		0	3.00
4.00	RESTRICTED CONTRIBUTIONS	5,304,741		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		5,304,741		0	10.00
11.00	Subtotal (line 3 plus line 10)		40,518,065		0	11.00
12.00	RELEASED FROM RESTRICTION	157,762		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		157,762		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		40,360,303		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	RESTRICTED CONTRIBUTIONS		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	RELEASED FROM RESTRICTION		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00



STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
11/21/2013 9:57 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	18,648,000		18,648,000	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)	18,648,000		18,648,000	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	18,648,000		18,648,000	17.00
18.00	Ancillary services	11,001,392	1,607,638	12,609,030	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC		0	0	24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	1,422,433	0	1,422,433	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	31,071,825	1,607,638	32,679,463	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		28,096,474		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		28,096,474		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 263303

Period:  
From 07/01/2012  
To 06/30/2013

Worksheet G-3

Date/Time Prepared:  
11/21/2013 9:57 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	32,679,463	1.00
2.00	Less contractual allowances and discounts on patients' accounts	7,463,997	2.00
3.00	Net patient revenues (line 1 minus line 2)	25,215,466	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	28,096,474	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,881,008	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	1,162,088	6.00
7.00	Income from investments	694,369	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	4,598	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	ELECTRONIC HEALTH RECORDS	1,372,525	24.00
24.01	UNREALIZED GAINS OR LOSSES	513,654	24.01
24.02	NET ASSETS RELEASED FROM RESTRICTION	157,762	24.02
24.03	OTHER INCOME	5,122	24.03
24.04	USDA GRANT INCOME	54,463	24.04
25.00	Total other income (sum of lines 6-24)	3,964,581	25.00
26.00	Total (line 5 plus line 25)	1,083,573	26.00
27.00		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)	1,083,573	29.00