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 07/01/2013 To 06/30/2014	Worksheet S Parts I-III Date/Time Prepared: 11/21/2014 3:05 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/21/2014 Time: 3:05 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RANKEN JORDAN (263303) for the cost reporting period beginning 07/01/2013 and ending 06/30/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed)_____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	0	0	0	3,383,262	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	0	0	0	3,383,262	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.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2014 3:04 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 11365 DORSETT ROAD	PO Box:			1.00
2.00	City: MARYLAND HEIGHTS	State: MO	Zip Code: 63043-	County: SAINT LOUIS	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	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:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2013	06/30/2014	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)			22.01
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 11/21/2014 3:04 pm

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	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	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 11/21/2014 3:04 pm

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

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2014 3:04 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME 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
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME 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	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00

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		V	XIX	
		1.00	2.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	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	109.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	194,250	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	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	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 11/21/2014 3:04 pm

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

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	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	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		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 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 11/21/2014 3:04 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		Y		Y	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	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	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MICHAEL	ALESSANDRINI	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3177137959	MALESSANDRINI@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 263303	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part II Date/Time Prepared: 11/21/2014 3:04 pm

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

			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		SENIOR MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I Date/Time Prepared: 11/21/2014 3:04 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	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)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2014 3:04 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	0	4,204	10,262			1.00
2.00	HMO and other (see instructions)	0	4,261				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	4,204	10,262			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	4,204	10,262	0.00	235.65	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	235.65	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	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2014 3:04 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	0	79	291	1.00
2.00	HMO and other (see instructions)			0	132		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	0	79	291	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
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 263303	Period: From 07/01/2013 To 06/30/2014	Worksheet S-10 Date/Time Prepared: 11/21/2014 3:04 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.695605	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	9,899,408	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	7,827,552	5.00
6.00	Medicaid charges	19,352,116	6.00
7.00	Medicaid cost (line 1 times line 6)	13,461,429	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
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	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	330,860	0	330,860	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	230,148	0	230,148	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	230,148	0	230,148	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	217,676	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)	217,676	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	151,417	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	381,565	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	381,565	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A | Date/Time Prepared: 11/21/2014 3:04 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,859,931	2,859,931	0	2,859,931	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	251,418	3,473,664	3,725,082	0	3,725,082	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,346,295	4,337,144	7,683,439	0	7,683,439	5.00
7.00	00700	OPERATION OF PLANT	390,446	562,766	953,212	0	953,212	7.00
10.00	01000	DIETARY	240,027	85,301	325,328	0	325,328	10.00
13.00	01300	NURSING ADMINISTRATION	880,431	5,187	885,618	0	885,618	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	189,050	59,851	248,901	0	248,901	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,434,576	469,570	6,904,146	0	6,904,146	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	58,765	58,765	0	58,765	54.00
60.00	06000	LABORATORY	0	60,558	60,558	0	60,558	60.00
65.00	06500	RESPIRATORY THERAPY	734,111	105,663	839,774	0	839,774	65.00
66.00	06600	PHYSICAL THERAPY	1,602,676	29,017	1,631,693	0	1,631,693	66.00
69.00	06900	ELECTROCARDIOLOGY	0	94,233	94,233	0	94,233	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	439,877	439,877	0	439,877	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	491,034	919,063	1,410,097	0	1,410,097	73.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,560,064	13,560,590	28,120,654	0	28,120,654	118.00
		NONREIMBURSABLE COST CENTERS						
200.00		TOTAL (SUM OF LINES 118-199)	14,560,064	13,560,590	28,120,654	0	28,120,654	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A | Date/Time Prepared: 11/21/2014 3:04 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-37,961	2,821,970		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-449,657	3,275,425		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,352,323	5,331,116		5.00
7.00	00700	OPERATION OF PLANT	0	953,212		7.00
10.00	01000	DIETARY	0	325,328		10.00
13.00	01300	NURSING ADMINISTRATION	0	885,618		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
17.00	01700	SOCIAL SERVICE	0	248,901		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,544,322	5,359,824		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	58,765		54.00
60.00	06000	LABORATORY	0	60,558		60.00
65.00	06500	RESPIRATORY THERAPY	0	839,774		65.00
66.00	06600	PHYSICAL THERAPY	0	1,631,693		66.00
69.00	06900	ELECTROCARDIOLOGY	0	94,233		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	439,877		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,410,097		73.00
		OTHER REIMBURSABLE COST CENTERS				
99.00	09900	CMHC	0	0		99.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,384,263	23,736,391		118.00
		NONREIMBURSABLE COST CENTERS				
200.00		TOTAL (SUM OF LINES 118-199)	-4,384,263	23,736,391		200.00

RECLASSIFICATIONS | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-6 | Date/Time Prepared: 11/21/2014 3:04 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DEFAULT					
1.00		0.00	0	0		1.00
	TOTALS		0	0		
500.00	Grand Total: Increases		0	0		500.00

RECLASSIFICATIONS | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-6 | Date/Time Prepared: 11/21/2014 3:04 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DEFAULT						
1.00		0.00	0	0	0		1.00
	TOTALS		0	0			
500.00	Grand Total: Decreases		0	0			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part I | Date/Time Prepared: 11/21/2014 3:04 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,359,177	0	0	0	0	1.00
2.00	Land Improvements	1,060,527	16,175	0	16,175	0	2.00
3.00	Buildings and Fixtures	20,887,985	98,306	0	98,306	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	10,977,976	596,118	0	596,118	28,712	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	35,285,665	710,599	0	710,599	28,712	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	35,285,665	710,599	0	710,599	28,712	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,359,177	0	1.00
2.00	Land Improvements	1,076,702	0	2.00
3.00	Buildings and Fixtures	20,986,291	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	11,545,382	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	35,967,552	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	35,967,552	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part II | Date/Time Prepared: 11/21/2014 3:04 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,859,931	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)	2,859,931	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	2,859,931		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	2,859,931		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part III Date/Time Prepared: 11/21/2014 3:04 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	35,967,552	0	35,967,552	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	35,967,552	0	35,967,552	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,859,931	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,859,931	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	-37,961	0	0	0	2,821,970	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	-37,961	0	0	0	2,821,970	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8 | Date/Time Prepared: 11/21/2014 3:04 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,543,453			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	-4,214	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	-94,614	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.03	LOBBYING EXPENSE	A	-869	ADULTS & PEDIATRICS	30.00	0	33.03

ADJUSTMENTS TO EXPENSES | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8 | Date/Time Prepared: 11/21/2014 3:04 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.04	MARKETING BENEFIT EXPENSE	A	-45,622	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05	MARKETING OTHER EXPENSE	A	-459,779	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.07	DEVELOPMENT BENEFIT EXPENSE	A	-50,508	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08	DEVELOPMENT OTHER EXPENSE	A	-349,764	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	MISCELLANEOUS REVENUE	B	-22,201	ADMINISTRATIVE & GENERAL	5.00	14	33.09
33.12	ALCOHOL EXPENSE	A	-58	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	HEALTH LINK ADMINISTRATIVE EXPENSES	A	12,231	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.15	PROVIDER-BASED PHYSICIAN BENEFITS	A	-353,527	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16	GIFTS IN KIND	A	-8,300	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.18	FRA ASSESSMENT FEE	A	-1,425,624	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	INTEREST INCOME	B	-37,961	CAP REL COSTS-BLDG & FIXT	1.00	11	33.19
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,384,263				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-1 | Date/Time Prepared: 11/21/2014 3:04 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	LEGAL FEES	114,447	114,447	1.00
2.00	7.00	OPERATION OF PLANT	HVAC REPAIRS	49,998	49,998	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			164,445	164,445	5.00

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

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

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

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

6.00	E	THOMAS MINOGUE	0.00	THOMPSON COBURN	0.00	6.00
7.00	E	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 07/01/2013 To 06/30/2014	Worksheet A-8-1 Date/Time Prepared: 11/21/2014 3:04 pm

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

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

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

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

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

6.00	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 07/01/2013 To 06/30/2014 | Worksheet A-8-2 | Date/Time Prepared: 11/21/2014 3:04 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,613,753	1,495,210	118,543	140,600	1,040	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			1,613,753	1,495,210	118,543		1,040	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	70,300	3,515	0	0	0	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			70,300	3,515	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	70,300	48,243	1,543,453		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			0	70,300	48,243	1,543,453		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I Date/Time Prepared: 11/21/2014 3:04 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,821,970	2,821,970				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,275,425	0	0	3,275,425		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,331,116	438,676	0	766,007	6,535,799	5.00
7.00	00700	OPERATION OF PLANT	953,212	425,849	0	89,378	1,468,439	7.00
10.00	01000	DIETARY	325,328	75,882	0	54,945	456,155	10.00
13.00	01300	NURSING ADMINISTRATION	885,618	184,486	0	201,541	1,271,645	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	248,901	72,231	0	43,276	364,408	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,359,824	1,330,492	0	1,472,955	8,163,271	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	58,765	0	0	0	58,765	54.00
60.00	06000	LABORATORY	60,558	0	0	0	60,558	60.00
65.00	06500	RESPIRATORY THERAPY	839,774	0	0	168,047	1,007,821	65.00
66.00	06600	PHYSICAL THERAPY	1,631,693	233,498	0	366,872	2,232,063	66.00
69.00	06900	ELECTROCARDIOLOGY	94,233	0	0	0	94,233	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	439,877	37,450	0	0	477,327	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,410,097	23,406	0	112,404	1,545,907	73.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,736,391	2,821,970	0	3,275,425	23,736,391	118.00
		NONREIMBURSABLE COST CENTERS						
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	23,736,391	2,821,970	0	3,275,425	23,736,391	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I Date/Time Prepared: 11/21/2014 3:04 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	DIETARY	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			5.00	7.00	10.00	13.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,535,799					5.00
7.00	00700	OPERATION OF PLANT	557,970	2,026,409				7.00
10.00	01000	DIETARY	173,327	78,556	708,038			10.00
13.00	01300	NURSING ADMINISTRATION	483,193	190,986	0	1,945,824		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	138,466	74,776	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,101,844	1,377,366	708,038	1,926,343	0	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,329	0	0	0	0	54.00
60.00	06000	LABORATORY	23,011	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	382,947	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	848,128	241,725	0	19,481	0	66.00
69.00	06900	ELECTROCARDIOLOGY	35,806	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	181,372	38,769	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	587,406	24,231	0	0	0	73.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,535,799	2,026,409	708,038	1,945,824	0	118.00
		NONREIMBURSABLE COST CENTERS						
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	6,535,799	2,026,409	708,038	1,945,824	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I Date/Time Prepared: 11/21/2014 3:04 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	577,650					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	577,650	15,854,512	0	15,854,512		30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	81,094	0	81,094		54.00
60.00	06000	LABORATORY	0	83,569	0	83,569		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,390,768	0	1,390,768		65.00
66.00	06600	PHYSICAL THERAPY	0	3,341,397	0	3,341,397		66.00
69.00	06900	ELECTROCARDIOLOGY	0	130,039	0	130,039		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	697,468	0	697,468		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,157,544	0	2,157,544		73.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0		99.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	577,650	23,736,391	0	23,736,391		118.00
		NONREIMBURSABLE COST CENTERS						
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	577,650	23,736,391	0	23,736,391		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 11/21/2014 3:04 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	438,676	0	438,676	0	5.00
7.00	00700	OPERATION OF PLANT	0	425,849	0	425,849	0	7.00
10.00	01000	DIETARY	0	75,882	0	75,882	0	10.00
13.00	01300	NURSING ADMINISTRATION	0	184,486	0	184,486	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	72,231	0	72,231	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,330,492	0	1,330,492	0	30.00
		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	233,498	0	233,498	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	37,450	0	37,450	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,406	0	23,406	0	73.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,821,970	0	2,821,970	0	118.00
		NONREIMBURSABLE COST CENTERS						
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	2,821,970	0	2,821,970	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II Date/Time Prepared: 11/21/2014 3:04 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	DIETARY	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			5.00	7.00	10.00	13.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	438,676					5.00
7.00	00700	OPERATION OF PLANT	37,451	463,300				7.00
10.00	01000	DIETARY	11,634	17,960	105,476			10.00
13.00	01300	NURSING ADMINISTRATION	32,432	43,665	0	260,583		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	9,294	17,096	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	208,188	314,909	105,476	257,974	0	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,499	0	0	0	0	54.00
60.00	06000	LABORATORY	1,544	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	25,703	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	56,927	55,266	0	2,609	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,403	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	12,174	8,864	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,427	5,540	0	0	0	73.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	438,676	463,300	105,476	260,583	0	118.00
		NONREIMBURSABLE COST CENTERS						
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	438,676	463,300	105,476	260,583	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 11/21/2014 3:04 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	98,621					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	98,621	2,315,660	0	2,315,660		30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,499	0	1,499		54.00
60.00	06000	LABORATORY	0	1,544	0	1,544		60.00
65.00	06500	RESPIRATORY THERAPY	0	25,703	0	25,703		65.00
66.00	06600	PHYSICAL THERAPY	0	348,300	0	348,300		66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,403	0	2,403		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	58,488	0	58,488		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	68,373	0	68,373		73.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0		99.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	98,621	2,821,970	0	2,821,970		118.00
		NONREIMBURSABLE COST CENTERS						
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	98,621	2,821,970	0	2,821,970		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/21/2014 3:04 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	60,283					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		60,283				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	14,308,646			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,371	9,371	3,346,295	-6,535,799	17,200,592	5.00
7.00	00700	OPERATION OF PLANT	9,097	9,097	390,446	0	1,468,439	7.00
10.00	01000	DIETARY	1,621	1,621	240,027	0	456,155	10.00
13.00	01300	NURSING ADMINISTRATION	3,941	3,941	880,431	0	1,271,645	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,543	1,543	189,050	0	364,408	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,422	28,422	6,434,576	0	8,163,271	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	58,765	54.00
60.00	06000	LABORATORY	0	0	0	0	60,558	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	734,111	0	1,007,821	65.00
66.00	06600	PHYSICAL THERAPY	4,988	4,988	1,602,676	0	2,232,063	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	94,233	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	800	800	0	0	477,327	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	500	500	491,034	0	1,545,907	73.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	60,283	60,283	14,308,646	-6,535,799	17,200,592	118.00
		NONREIMBURSABLE COST CENTERS						
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,821,970	0	3,275,425		6,535,799	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	46.812037	0.000000	0.228912		0.379975	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		438,676	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.025504	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/21/2014 3:04 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			7.00	10.00	13.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	41,815					7.00
10.00	01000	DIETARY	1,621	30,873				10.00
13.00	01300	NURSING ADMINISTRATION	3,941	0	159,810			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0		16.00
17.00	01700	SOCIAL SERVICE	1,543	0	0	0	100	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,422	30,873	158,210	0	100	30.00
		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	4,988	0	1,600	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	800	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	500	0	0	0	0	73.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	41,815	30,873	159,810	0	100	118.00
		NONREIMBURSABLE COST CENTERS						
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,026,409	708,038	1,945,824	0	577,650	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	48.461294	22.933890	12.175859	0.000000	5,776.500000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	463,300	105,476	260,583	0	98,621	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	11.079756	3.416448	1.630580	0.000000	986.210000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/21/2014 3:04 pm

Title XVIII | Hospital | Tefra

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,854,512		15,854,512	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	81,094		81,094	0	0	54.00
60.00	06000	LABORATORY	83,569		83,569	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,390,768	0	1,390,768	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,341,397	0	3,341,397	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	130,039		130,039	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	697,468		697,468	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,157,544		2,157,544	0	0	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)	23,736,391	0	23,736,391	0	0	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	23,736,391	0	23,736,391	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/21/2014 3:04 pm

Title XVIII | Hospital | Tefra

		Cost Center Description	Charges					
			Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,261,617		21,261,617			30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	123,591	0	123,591	0.656148	0.656148	54.00
60.00	06000	LABORATORY	58,141	0	58,141	1.437351	1.437351	60.00
65.00	06500	RESPIRATORY THERAPY	6,973,873	0	6,973,873	0.199425	0.199425	65.00
66.00	06600	PHYSICAL THERAPY	1,891,898	2,287,455	4,179,353	0.799501	0.799501	66.00
69.00	06900	ELECTROCARDIOLOGY	182,475	0	182,475	0.712640	0.712640	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	377,587	0	377,587	1.847172	1.847172	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	966,740	0	966,740	2.231773	2.231773	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)	31,835,922	2,287,455	34,123,377			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	31,835,922	2,287,455	34,123,377			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/21/2014 3:04 pm

Title XVIII | Hospital | Tefra

		Cost Center Description	PPS Inpatient Ratio	
			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 PAT	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 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/21/2014 3:04 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,854,512		15,854,512	48,243	15,902,755	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	81,094		81,094	0	81,094	54.00
60.00	06000	LABORATORY	83,569		83,569	0	83,569	60.00
65.00	06500	RESPIRATORY THERAPY	1,390,768	0	1,390,768	0	1,390,768	65.00
66.00	06600	PHYSICAL THERAPY	3,341,397	0	3,341,397	0	3,341,397	66.00
69.00	06900	ELECTROCARDIOLOGY	130,039		130,039	0	130,039	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	697,468		697,468	0	697,468	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,157,544		2,157,544	0	2,157,544	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)	23,736,391	0	23,736,391	48,243	23,784,634	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	23,736,391	0	23,736,391	48,243	23,784,634	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/21/2014 3:04 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges					
			Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,261,617		21,261,617			30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	123,591	0	123,591	0.656148	0.000000	54.00
60.00	06000	LABORATORY	58,141	0	58,141	1.437351	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	6,973,873	0	6,973,873	0.199425	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,891,898	2,287,455	4,179,353	0.799501	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	182,475	0	182,475	0.712640	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	377,587	0	377,587	1.847172	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	966,740	0	966,740	2.231773	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)	31,835,922	2,287,455	34,123,377			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	31,835,922	2,287,455	34,123,377			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/21/2014 3:04 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		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 PAT	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 07/01/2013 To 06/30/2014 | Worksheet D Part I Date/Time Prepared: 11/21/2014 3:04 pm

Title XVIII | Hospital | Tefra

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,315,660	0	2,315,660	10,262	225.65	30.00
200.00	Total (lines 30-199)	2,315,660		2,315,660	10,262		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	0	0		30.00
200.00	Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part II Date/Time Prepared: 11/21/2014 3:04 pm

Title XVIII | Hospital | Tefra

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,499	123,591	0.012129	0	0	54.00
60.00	06000	LABORATORY	1,544	58,141	0.026556	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	25,703	6,973,873	0.003686	0	0	65.00
66.00	06600	PHYSICAL THERAPY	348,300	4,179,353	0.083338	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,403	182,475	0.013169	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	58,488	377,587	0.154899	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,373	966,740	0.070725	0	0	73.00
200.00		Total (lines 50-199)	506,310	12,861,760		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part III Date/Time Prepared: 11/21/2014 3:04 pm

Title XVIII | Hospital | Tefra

		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	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	10,262	0.00	0	0		30.00
200.00		Total (lines 30-199)	10,262		0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 11/21/2014 3:04 pm

Title XVIII | Hospital | Tefra

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
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 PAT	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 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 11/21/2014 3:04 pm

Title XVIII | Hospital | Tefra

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	123,591	0.000000	0.000000	0	54.00
60.00	06000	LABORATORY	0	58,141	0.000000	0.000000	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,973,873	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	4,179,353	0.000000	0.000000	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	182,475	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	377,587	0.000000	0.000000	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	966,740	0.000000	0.000000	0	73.00
200.00		Total (lines 50-199)	0	12,861,760			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 11/21/2014 3:04 pm

Title XVIII | Hospital | Tefra

		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	0	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	35,471	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
200.00		Total (lines 50-199)	0	35,471	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 11/21/2014 3:04 pm

Title XVIII | Hospital | Tefra

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.656148	0	0	0	0	54.00
60.00	06000	LABORATORY	1.437351	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.199425	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.799501	35,471	0	0	28,359	66.00
69.00	06900	ELECTROCARDIOLOGY	0.712640	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1.847172	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2.231773	0	0	0	0	73.00
200.00		Subtotal (see instructions)		35,471	0	0	28,359	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		35,471	0	0	28,359	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 11/21/2014 3:04 pm

Title XVIII | Hospital | Tefra

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
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 PAT	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 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 11/21/2014 3:04 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.656148	0	0	0	0	54.00
60.00	06000	LABORATORY	1.437351	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.199425	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.799501	0	123,496	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.712640	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1.847172	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2.231773	0	0	0	0	73.00
200.00		Subtotal (see instructions)		0	123,496	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	123,496	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 11/21/2014 3:04 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
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	98,735	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
200.00		Subtotal (see instructions)	98,735	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	98,735	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/21/2014 3:04 pm

Title XVIII | Hospital | Tefra

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	10,262	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,262	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)	10,262	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)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	15,854,512	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)	15,854,512	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	15,854,512	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,544.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	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)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/21/2014 3:04 pm

Title XVIII | Hospital | Tefra

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	0	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)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	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 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/21/2014 3:04 pm

Title XVIII | Hospital | Tefra

	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	2,315,660	15,854,512	0.146057	0	0	90.00
91.00	Nursing School cost	0	15,854,512	0.000000	0	0	91.00
92.00	Allied health cost	0	15,854,512	0.000000	0	0	92.00
93.00	All other Medical Education	0	15,854,512	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/21/2014 3:04 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	10,262	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,262	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)	10,262	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)	4,204	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	15,854,512	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)	15,854,512	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	15,854,512	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,544.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	6,495,054	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)	6,495,054	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/21/2014 3:04 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,588,752	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	9,083,806	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)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	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 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/21/2014 3:04 pm

Title XIX | Hospital | Cost

	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	2,315,660	15,854,512	0.146057	0	0	90.00
91.00	Nursing School cost	0	15,854,512	0.000000	0	0	91.00
92.00	Allied health cost	0	15,854,512	0.000000	0	0	92.00
93.00	All other Medical Education	0	15,854,512	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-3 | Date/Time Prepared: 11/21/2014 3:04 pm

Title XIX | Hospital | Cost

		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		7,567,200		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.656148	29,371	19,272	54.00
60.00	06000	LABORATORY	1.437351	37,420	53,786	60.00
65.00	06500	RESPIRATORY THERAPY	0.199425	3,585,420	715,022	65.00
66.00	06600	PHYSICAL THERAPY	0.799501	515,493	412,137	66.00
69.00	06900	ELECTROCARDIOLOGY	0.712640	66,577	47,445	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1.847172	193,897	358,161	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2.231773	440,425	982,929	73.00
200.00		Total (sum of lines 50-94 and 96-98)		4,868,603	2,588,752	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		4,868,603		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 263303	Period: From 07/01/2013 To 06/30/2014	Worksheet E Part B Date/Time Prepared: 11/21/2014 3:04 pm
	Title XVIII	Hospital	Tefra

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	28,359	2.00
3.00	PPS payments	6,567	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
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
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
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	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 physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	6,567	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	1,313	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	5,254	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)	5,254	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	5,254	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	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)	5,254	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	5,254	40.00
40.01	Sequestration adjustment (see instructions)	105	40.01
41.00	Interim payments	5,149	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E-1 Part I Date/Time Prepared: 11/21/2014 3:04 pm

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		0		5,149	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)		0		5,149	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		5,149	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 07/01/2013 To 06/30/2014	Worksheet E-3 Part I Date/Time Prepared: 11/21/2014 3:04 pm
	Title XVIII	Hospital	Tefra

		1.00	
	PART I - MEDICARE PART A SERVICES - TEFRA		
1.00	Inpatient hospital services (see instructions)	0	1.00
2.00	Organ acquisition	0	2.00
3.00	Cost of physicians' services in a teaching hospital (see instructions)	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	0	4.00
5.00	Primary payer payments	0	5.00
6.00	Subtotal (line 4 less line 5).	0	6.00
7.00	Deductibles	0	7.00
8.00	Subtotal (line 6 minus line 7)	0	8.00
9.00	Coinsurance	0	9.00
10.00	Subtotal (line 8 minus line 9)	0	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)	0	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)	0	18.00
18.01	Sequestration adjustment (see instructions)	0	18.01
19.00	Interim payments	0	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	0	21.00
22.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	22.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 263303	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part VII Date/Time Prepared: 11/21/2014 3:04 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	9,083,806		1.00
2.00	Medical and other services		98,735	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	9,083,806	98,735	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)	9,083,806	98,735	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	7,567,200		8.00
9.00	Ancillary service charges	4,868,603	123,496	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)	12,435,803	123,496	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	12,435,803	123,496	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	3,351,997	24,761	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	9,083,806	98,735	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	9,083,806	98,735	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	9,083,806	98,735	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	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)	9,083,806	98,735	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	9,083,806	98,735	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)	9,083,806	98,735	40.00
41.00	Interim payments	5,702,458	96,821	41.00
42.00	Balance due provider/program (line 40 minus line 41)	3,381,348	1,914	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §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 07/01/2013 To 06/30/2014 | Worksheet G | Date/Time Prepared: 11/21/2014 3:04 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	232,089	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	3,381,151	0	0	0	4.00
5.00	Other receivable	1,191,284	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	1,667,588	0	0	0	8.00
9.00	Other current assets	1,191,282	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)	7,663,394	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,435,879	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	19,740,704	0	0	0	15.00
16.00	Accumulated depreciation	-4,946,296	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	12,790,969	0	0	0	23.00
24.00	Accumulated depreciation	-4,313,797	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)	26,707,459	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	5,335,421	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	24,840,290	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	30,175,711	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	64,546,564	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	766,869	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,984,427	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,077,621	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	113,661	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,942,578	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	17,931,905	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	810,957	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	18,742,862	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	22,685,440	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	41,861,124				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)	41,861,124	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	64,546,564	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 263303 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G-1 | Date/Time Prepared: 11/21/2014 3:04 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		40,360,303		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		57,799				2.00
3.00	Total (sum of line 1 and line 2)		40,418,102		0		3.00
4.00	RESTRICTED CONTRIBUTIONS	1,547,406		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		1,547,406		0		10.00
11.00	Subtotal (line 3 plus line 10)		41,965,508		0		11.00
12.00	RELEASED FROM RESTRICTION	104,384		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		104,384		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		41,861,124		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 07/01/2013 To 06/30/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/21/2014 3:04 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	21,261,617		21,261,617	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)	21,261,617		21,261,617	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)	21,261,617		21,261,617	17.00
18.00	Ancillary services	10,574,305	2,287,455	12,861,760	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	PHYSICIAN FEES	0	2,406,339	2,406,339	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	31,835,922	4,693,794	36,529,716	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		28,120,654		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)		28,120,654		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 263303	Period: From 07/01/2013 To 06/30/2014	Worksheet G-3 Date/Time Prepared: 11/21/2014 3:04 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	36,529,716	1.00
2.00	Less contractual allowances and discounts on patients' accounts	12,426,997	2.00
3.00	Net patient revenues (line 1 minus line 2)	24,102,719	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	28,120,654	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,017,935	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	1,937,530	6.00
7.00	Income from investments	1,306,893	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	69,640	24.00
24.01	NET ASSETS RELEASED FROM RESTRICTIO	104,384	24.01
24.02	UNREALIZED GAINS OR LOSSES	657,287	24.02
25.00	Total other income (sum of lines 6-24)	4,075,734	25.00
26.00	Total (line 5 plus line 25)	57,799	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	57,799	29.00