

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: 140011	Period: From 04/01/2012 To 03/31/2013	Worksheet S Parts I-III Date/Time Prepared: 8/19/2013 3:15 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date:	Time:
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HERRIN HOSPITAL (140011) for the cost reporting period beginning 04/01/2012 and ending 03/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____ Title

_____ Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	1,626,916	-1,043,148	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	-45,505	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
200.00 Total	0	1,581,411	-1,043,148	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140011			Period: From 04/01/2012 To 03/31/2013		Worksheet S-2 Part I Date/Time Prepared: 8/19/2013 3:15 pm					
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 201 S. 14TH STREET			PO Box:						1.00		
2.00	City: HERRIN			State: IL		Zip Code: 62948		County: WILLIAMSON		2.00		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		HERRIN HOSPITAL		140011	99914	1	07/01/1966	N	P	0	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF		HERRIN HOSPITAL ACUTE REHAB		14T011	99914	5	04/01/1998	N	P	0	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)						04/01/2012	03/31/2013		20.00		
21.00	Type of Control (see instructions)						2		21.00			
Inpatient PPS Information												
22.00	Does this facility qualify for 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.						Y	N		22.00		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3	N		23.00		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
				1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			1,366	330	0	0	5	146	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.			580	87	0	0	0	13	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.						2			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.						2			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: 140011	Period: From 04/01/2012 To 03/31/2013	Worksheet S-2 Part I Date/Time Prepared: 8/19/2013 3:15 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	1				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.	04/01/2012	03/31/2013			38.00
		Y/N	Y/N			
		1.00	2.00			
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.	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.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.					58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00		61.00
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		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet S-2
Part I
Date/Time Prepared:
8/19/2013 3:15 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	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. 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
		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	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

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		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 a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			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.	Y				75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	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		N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	97.00
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)					106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)					107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00
				1.00	2.00	3.00
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	2,470,060	0		0
				1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		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	Y	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y	14H124	140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: SOUTHERN ILLINOIS HEALTHCARE	Contractor's Name: NGS		Contractor's Number: 00131	
142.00	Street: 1239 E. MAIN ST.	PO Box: 3988			
143.00	City: CARBONDALE	State: IL		Zip Code: 62902-3988	
				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.			Y	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
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N

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								1.00	
Multi campus									
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5							0.00	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)								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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140011	Period: From 04/01/2012 To 03/31/2013	Worksheet S-2 Part II Date/Time Prepared: 8/19/2013 3:15 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			Y	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)	Y	06/28/2013	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet S-2
Part II
Date/Time Prepared:
8/19/2013 3:15 pm

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			Y	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			Y	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.			Y	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			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.	LUANNE		WARREN	
42.00	Enter the employer/company name of the cost report preparer.	SOUTHERN ILLINOIS HEALTHCARE			
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	618-457-5200 X67202		LUANNE.WARREN@SIH.NET	

		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)	06/28/2013		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
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.	REIMBURSEMENT DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HFS Supplemental Information		Provider CCN: 140011	Period: From 04/01/2012 To 03/31/2013	Worksheet S-2 Part IX Date/Time Prepared: 8/19/2013 3:15 pm
		Title V	Title XIX	
		1.00	2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient	Outpatient	
		1.00	2.00	
CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
RCE DISALLOWANCE				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet S-3
Part I
Date/Time Prepared:
8/19/2013 3:15 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	77	28,105	0.00	0	1.00
2.00 HMO						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)		77	28,105	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		85	31,025	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	29	10,585		0	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
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		114				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet S-3
Part I
Date/Time Prepared:
8/19/2013 3:15 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	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)	10,430	1,491	14,900			1.00
2.00 HMO	202	151				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	40	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	10,430	1,491	14,900			7.00
8.00 INTENSIVE CARE UNIT	1,263	205	2,127			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)	11,693	1,696	17,027	0.00	627.91	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	5,581	667	7,680	0.00	53.35	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
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	681.26	27.00
28.00 Observation Bed Days		441	2,974			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet S-3
Part I
Date/Time Prepared:
8/19/2013 3:15 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)			0	3,030	567	4,756	1.00
2.00 HMO				0			2.00
3.00 HMO IPF Subprovider							3.00
4.00 HMO IRF Subprovider							4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0	3,030	567	4,756	14.00	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF	0.00	0	492	47	643	17.00	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
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
33.00 LTCH non-covered days							33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet S-3
Part II
Date/Time Prepared:
8/19/2013 3:15 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	34,018,244	0	34,018,244	1,417,025.03	24.01
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		3,698	0	3,698	680.00	5.44
6.00	Non-physician-Part B		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		2,454,999	0	2,454,999	110,974.18	22.12
OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		225,529	0	225,529	4,356.59	51.77
12.00	Contract management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		224,352	0	224,352	1,482.00	151.38
14.00	Home office salaries & wage-related costs		7,270,335	0	7,270,335	176,482.03	41.20
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		8,926,871	0	8,926,871		
18.00	Wage-related costs (other) Wkst S-3, Part IV line 25		0	0	0		
19.00	Excluded areas		694,416	0	694,416		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		1,046	0	1,046		
24.00	Wage-related costs (RHC/FOHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits	4.00	239,500	0	239,500	9,888.00	24.22
27.00	Administrative & General	5.00	4,120,980	0	4,120,980	120,518.88	34.19
28.00	Administrative & General under contract (see inst.)		251,570	0	251,570	757.89	331.93
29.00	Maintenance & Repairs	6.00	556,056	0	556,056	25,545.82	21.77
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00
31.00	Laundry & Linen Service	8.00	39,169	0	39,169	3,284.17	11.93
32.00	Housekeeping	9.00	824,921	0	824,921	67,387.35	12.24
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	940,038	-602,167	337,871	23,507.05	14.37
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	602,167	602,167	41,899.34	14.37
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	1,184,472	0	1,184,472	40,476.62	29.26
39.00	Central Services and Supply	14.00	169,611	0	169,611	11,991.28	14.14
40.00	Pharmacy	15.00	0	0	0	0.00	0.00
41.00	Medical Records & Medical Records Library	16.00	344,197	0	344,197	22,599.05	15.23

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet S-3
Part II
Date/Time Prepared:
8/19/2013 3:15 pm

		Worksheet A Line Number	Amount Reported	Reclassifi- cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet S-3
Part III
Date/Time Prepared:
8/19/2013 3:15 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	34,266,116	0	34,266,116	1,417,102.92	24.18	1.00
2.00	Excluded area salaries (see instructions)	2,454,999	0	2,454,999	110,974.18	22.12	2.00
3.00	Subtotal salaries (line 1 minus line 2)	31,811,117	0	31,811,117	1,306,128.74	24.36	3.00
4.00	Subtotal other wages & related costs (see inst.)	7,720,216	0	7,720,216	182,320.62	42.34	4.00
5.00	Subtotal wage-related costs (see inst.)	8,926,871	0	8,926,871	0.00	28.06	5.00
6.00	Total (sum of lines 3 thru 5)	48,458,204	0	48,458,204	1,488,449.36	32.56	6.00
7.00	Total overhead cost (see instructions)	8,670,514	0	8,670,514	367,855.45	23.57	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140011	Period: From 04/01/2012 To 03/31/2013	Worksheet S-3 Part IV Date/Time Prepared: 8/19/2013 3:15 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		592,177	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		524,451	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees		713	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		7,501,633	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		12,337	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		63,117	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		115,030	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		532,035	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		2,390,925	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		86,964	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		79,023	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		11,898,405	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet S-3
Part V
Date/Time Prepared:
8/19/2013 3:15 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	225,529	8,926,871	1.00
2.00	Hospital	225,529	8,926,871	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140011	Period: From 04/01/2012 To 03/31/2013	Worksheet S-10 Date/Time Prepared: 8/19/2013 3:15 pm
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				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)			0.257664	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			5,560,968	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			87,004	5.00
6.00	Medicaid charges			62,692,945	6.00
7.00	Medicaid cost (line 1 times line 6)			16,153,715	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)			10,505,743	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			13,562	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			10,505,743	19.00
				1.00	
				2.00	
				3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	11,050,078	1,200,388	12,250,466	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	2,847,207	309,297	3,156,504	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)	2,847,207	309,297	3,156,504	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)			13,180,690	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			842,088	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)			12,338,602	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)			3,179,214	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)			6,335,718	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			16,841,461	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet A
Date/Time Prepared:
8/19/2013 3:15 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		3,335,703	3,335,703	267,353	3,603,056	1.00
2.00	00200		2,328,228	2,328,228	95,356	2,423,584	2.00
4.00	00400	239,500	11,997,715	12,237,215	-1,319	12,235,896	4.00
5.02	00520	0	0	0	0	0	5.02
5.03	00530	0	72,594	72,594	0	72,594	5.03
5.04	00550	692,112	63,751	755,863	0	755,863	5.04
5.05	00560	3,428,868	6,608,187	10,037,055	-12,195	10,024,860	5.05
6.00	00600	556,056	1,119,715	1,675,771	0	1,675,771	6.00
8.00	00800	39,169	408,995	448,164	0	448,164	8.00
9.00	00900	824,921	287,194	1,112,115	0	1,112,115	9.00
10.00	01000	940,038	623,200	1,563,238	-1,001,374	561,864	10.00
11.00	01100	0	0	0	1,001,374	1,001,374	11.00
13.00	01300	1,184,472	85,844	1,270,316	0	1,270,316	13.00
14.00	01400	169,611	62,763	232,374	-2,538	229,836	14.00
16.00	01600	344,197	25,392	369,589	0	369,589	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	853,194	853,194	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	5,764,700	3,017,490	8,782,190	-4,653	8,777,537	30.00
31.00	03100	1,461,057	505,749	1,966,806	-6,617	1,960,189	31.00
41.00	04100	2,454,999	1,996,160	4,451,159	-371	4,450,788	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,636,846	7,779,400	10,416,246	-5,957,928	4,458,318	50.00
51.00	05100	244,919	35,075	279,994	-99	279,895	51.00
53.00	05300	23,172	1,042,781	1,065,953	-903,642	162,311	53.00
54.00	05400	2,000,036	620,704	2,620,740	-158,834	2,461,906	54.00
56.00	05600	287,699	1,071,263	1,358,962	35,875	1,394,837	56.00
57.00	05700	422,754	459,978	882,732	-599	882,133	57.00
58.00	05800	221,176	210,649	431,825	-29,480	402,345	58.00
60.00	06000	1,404,721	2,998,909	4,403,630	-1,739	4,401,891	60.00
65.00	06500	1,027,711	286,270	1,313,981	-83,129	1,230,852	65.00
66.00	06600	2,227,429	367,052	2,594,481	0	2,594,481	66.00
69.00	06900	484,426	233,950	718,376	-42,177	676,199	69.00
71.00	07100	0	0	0	3,634,347	3,634,347	71.00
72.00	07200	0	0	0	2,522,949	2,522,949	72.00
73.00	07300	1,606,627	3,997,901	5,604,528	171,645	5,776,173	73.00
76.97	07697	375,140	29,939	405,079	0	405,079	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	165,954	315,671	481,625	-6,970	474,655	90.00
91.00	09100	2,789,934	2,844,453	5,634,387	-5,720	5,628,667	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		2,278,191	2,278,191	-362,709	1,915,482	113.00
118.00		34,018,244	57,110,866	91,129,110	0	91,129,110	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	79,357	79,357	0	79,357	192.00
192.01	19201	0	0	0	0	0	192.01
200.00		34,018,244	57,190,223	91,208,467	0	91,208,467	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet A
Date/Time Prepared:
8/19/2013 3:15 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	149,127	3,752,183	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,156,216	4,579,800	2.00
4.00	00400	EMPLOYEE BENEFITS	443,412	12,679,308	4.00
5.02	00520	DATA PROCESSING	3,115,140	3,115,140	5.02
5.03	00530	PURCHASING RECEIVING AND STORES	-10,740	61,854	5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE	1,957,408	2,713,271	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	1,900,770	11,925,630	5.05
6.00	00600	MAINTENANCE & REPAIRS	-173	1,675,598	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	448,164	8.00
9.00	00900	HOUSEKEEPING	0	1,112,115	9.00
10.00	01000	DIETARY	0	561,864	10.00
11.00	01100	CAFETERIA	-330,253	671,121	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,270,316	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	229,836	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-47,680	321,909	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-853,194	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,453,151	7,324,386	30.00
31.00	03100	INTENSIVE CARE UNIT	-22,227	1,937,962	31.00
41.00	04100	SUBPROVIDER - I RF	-1,247,275	3,203,513	41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-71,315	4,387,003	50.00
51.00	05100	RECOVERY ROOM	0	279,895	51.00
53.00	05300	ANESTHESIOLOGY	0	162,311	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,510	2,459,396	54.00
56.00	05600	RADIOISOTOPE	0	1,394,837	56.00
57.00	05700	CT SCAN	0	882,133	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	402,345	58.00
60.00	06000	LABORATORY	-32,200	4,369,691	60.00
65.00	06500	RESPIRATORY THERAPY	-5,979	1,224,873	65.00
66.00	06600	PHYSICAL THERAPY	0	2,594,481	66.00
69.00	06900	ELECTROCARDIOLOGY	-108,410	567,789	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,634,347	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,522,949	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,776,173	73.00
76.97	07697	CARDIAC REHABILITATION	-1,408	403,671	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-3,698	470,957	90.00
91.00	09100	EMERGENCY	-1,785,310	3,843,357	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-1,915,482	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,831,068	92,960,178	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	79,357	192.00
192.01	19201	VACANT SPACE	0	0	192.01
200.00		TOTAL (SUM OF LINES 118-199)	1,831,068	93,039,535	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet Non-CMS W
Date/Time Prepared:
8/19/2013 3:15 pm

Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
	1.00	2.00	
GENERAL SERVICE COST CENTERS			
1.00 CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00 EMPLOYEE BENEFITS	00400		4.00
5.02 DATA PROCESSING	00520		5.02
5.03 PURCHASING RECEIVING AND STORES	00530		5.03
5.04 CASHIERING/ACCOUNTS RECEIVABLE	00550		5.04
5.05 OTHER ADMINISTRATIVE AND GENERAL	00560		5.05
6.00 MAINTENANCE & REPAIRS	00600		6.00
8.00 LAUNDRY & LINEN SERVICE	00800		8.00
9.00 HOUSEKEEPING	00900		9.00
10.00 DIETARY	01000		10.00
11.00 CAFETERIA	01100		11.00
13.00 NURSING ADMINISTRATION	01300		13.00
14.00 CENTRAL SERVICES & SUPPLY	01400		14.00
16.00 MEDICAL RECORDS & LIBRARY	01600		16.00
17.00 SOCIAL SERVICE	01700		17.00
19.00 NONPHYSICIAN ANESTHETISTS	01900		19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS	03000		30.00
31.00 INTENSIVE CARE UNIT	03100		31.00
41.00 SUBPROVIDER - IRF	04100		41.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	05000		50.00
51.00 RECOVERY ROOM	05100		51.00
53.00 ANESTHESIOLOGY	05300		53.00
54.00 RADIOLOGY-DIAGNOSTIC	05400		54.00
56.00 RADIOISOTOPE	05600		56.00
57.00 CT SCAN	05700		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
60.00 LABORATORY	06000		60.00
65.00 RESPIRATORY THERAPY	06500		65.00
66.00 PHYSICAL THERAPY	06600		66.00
69.00 ELECTROCARDIOLOGY	06900		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00 DRUGS CHARGED TO PATIENTS	07300		73.00
76.97 CARDIAC REHABILITATION	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
90.00 CLINIC	09000		90.00
91.00 EMERGENCY	09100		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
SPECIAL PURPOSE COST CENTERS			
113.00 INTEREST EXPENSE	11300		113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS			
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00 PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.01 VACANT SPACE	19201		192.01
200.00 TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet A-6

Date/Time Prepared:
8/19/2013 3:15 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	602,167	399,207	1.00
	TOTALS		602,167	399,207	
B - MEDICAL SUPPLY RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	6,157,296	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
	TOTALS		0	6,157,296	
C - CRNA RECLASS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	853,194	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	853,194	
D - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	267,353	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	95,356	2.00
	TOTALS		0	362,709	
E - BARIATRIC PROGRAM RECLASS					
1.00	OPERATING ROOM	50.00	0	12,000	1.00
	TOTALS		0	12,000	
F - IMPLANTABLE DEVICES RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,522,949	1.00
	TOTALS		0	2,522,949	
G - RADIOLOGY SCHEDULER RECLASS					
1.00	CT SCAN	57.00	61,229	0	1.00
2.00	RADIOISOTOPE	56.00	35,875	0	2.00
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	15,193	0	3.00
	TOTALS		112,297	0	
H - CONTRAST DRUG RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	172,637	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	TOTALS		0	172,637	
500.00	Grand Total: Increases		714,464	10,479,992	500.00

RECLASSIFICATIONS

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet A-6

Date/Time Prepared:
8/19/2013 3:15 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA RECLASS							
1.00	DIETARY	10.00	602,167	399,207	0		1.00
	TOTALS		602,167	399,207			
B - MEDICAL SUPPLY RECLASS							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	195	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	4,653	0		2.00
3.00	SUBPROVIDER - IRF	41.00	0	371	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	6,617	0		4.00
5.00	OPERATING ROOM	50.00	0	5,969,928	0		5.00
6.00	RECOVERY ROOM	51.00	0	99	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,538	0		7.00
8.00	EMERGENCY	91.00	0	5,720	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	51,767	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	20,692	0		10.00
11.00	CT SCAN	57.00	0	1,886	0		11.00
12.00	LABORATORY	60.00	0	1,739	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	83,129	0		13.00
14.00	CLINIC	90.00	0	6,970	0		14.00
15.00	DRUGS CHARGED TO PATIENTS	73.00	0	992	0		15.00
	TOTALS		0	6,157,296			
C - CRNA RECLASS							
1.00	ANESTHESIOLOGY	53.00	0	851,875	0		1.00
2.00	EMPLOYEE BENEFITS	4.00	0	1,319	0		2.00
	TOTALS		0	853,194			
D - INTEREST RECLASS							
1.00	INTEREST EXPENSE	113.00	0	362,709	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	362,709			
E - BARIATRIC PROGRAM RECLASS							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	12,000	0		1.00
	TOTALS		0	12,000			
F - IMPLANTABLE DEVICES RECLASS							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,522,949	0		1.00
	TOTALS		0	2,522,949			
G - RADIOLOGY SCHEDULER RECLASS							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	112,297	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		112,297	0			
H - CONTRAST DRUG RECLASS							
1.00	ELECTROCARDIOLOGY	69.00	0	42,177	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	25,845	0		2.00
3.00	CT SCAN	57.00	0	59,942	0		3.00
4.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	44,673	0		4.00
	TOTALS		0	172,637			
500.00	Grand Total: Decreases		714,464	10,479,992			500.00

RECLASSIFICATIONS

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
8/19/2013 3:15 pm

Increases			Decreases			
Cost Center	Line #	Salary	Cost Center	Line #	Salary	
2.00	3.00	4.00	6.00	7.00	8.00	
A - CAFETERIA RECLASS						
1.00	CAFETERIA	11.00	602,167	DIETARY	10.00	602,167
	TOTALS		602,167	TOTALS		602,167
B - MEDICAL SUPPLY RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	OTHER ADMINISTRATIVE AND GENERAL	5.05	0
2.00		0.00	0	ADULTS & PEDIATRICS	30.00	0
3.00		0.00	0	SUBPROVIDER - IRF	41.00	0
4.00		0.00	0	INTENSIVE CARE UNIT	31.00	0
5.00		0.00	0	OPERATING ROOM	50.00	0
6.00		0.00	0	RECOVERY ROOM	51.00	0
7.00		0.00	0	CENTRAL SERVICES & SUPPLY	14.00	0
8.00		0.00	0	EMERGENCY	91.00	0
9.00		0.00	0	ANESTHESIOLOGY	53.00	0
10.00		0.00	0	RADIOLOGY-DIAGNOSTIC	54.00	0
11.00		0.00	0	CT SCAN	57.00	0
12.00		0.00	0	LABORATORY	60.00	0
13.00		0.00	0	RESPIRATORY THERAPY	65.00	0
14.00		0.00	0	CLINIC	90.00	0
15.00		0.00	0	DRUGS CHARGED TO PATIENTS	73.00	0
	TOTALS			TOTALS		0
C - CRNA RECLASS						
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	ANESTHESIOLOGY	53.00	0
2.00		0.00	0	EMPLOYEE BENEFITS	4.00	0
	TOTALS			TOTALS		0
D - INTEREST RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	INTEREST EXPENSE	113.00	0
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0		0.00	0
	TOTALS			TOTALS		0
E - BARIATRIC PROGRAM RECLASS						
1.00	OPERATING ROOM	50.00	0	OTHER ADMINISTRATIVE AND GENERAL	5.05	0
	TOTALS			TOTALS		0
F - IMPLANTABLE DEVICES RECLASS						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0
	TOTALS			TOTALS		0
G - RADIOLOGY SCHEDULER RECLASS						
1.00	CT SCAN	57.00	61,229	RADIOLOGY-DIAGNOSTIC	54.00	112,297
2.00	RADIOISOTOPE	56.00	35,875		0.00	0
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	15,193		0.00	0
	TOTALS		112,297	TOTALS		112,297
H - CONTRAST DRUG RECLASS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	ELECTROCARDIOLOGY	69.00	0
2.00		0.00	0	RADIOLOGY-DIAGNOSTIC	54.00	0
3.00		0.00	0	CT SCAN	57.00	0
4.00		0.00	0	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0
	TOTALS			TOTALS		0
500.00	Grand Total: Increases		714,464	Grand Total: Decreases		714,464

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet A-7
Part I
Date/Time Prepared:
8/19/2013 3:15 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	3,613,594	82,840	0	82,840	0	1.00
2.00	Land Improvements	4,062,560	200,512	0	200,512	20,752	2.00
3.00	Buildings and Fixtures	35,417,643	1,629,033	0	1,629,033	107,866	3.00
4.00	Building Improvements	27,692,853	1,403,889	0	1,403,889	294,684	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	24,097,686	2,318,917	0	2,318,917	1,437,423	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	94,884,336	5,635,191	0	5,635,191	1,860,725	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	94,884,336	5,635,191	0	5,635,191	1,860,725	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,696,434	0				1.00
2.00	Land Improvements	4,242,320	0				2.00
3.00	Buildings and Fixtures	36,938,810	0				3.00
4.00	Building Improvements	28,802,058	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	24,979,180	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	98,658,802	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	98,658,802	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet A-7
Part II
Date/Time Prepared:
8/19/2013 3:15 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	3,335,703	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,328,228	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,663,931	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	3,335,703				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,328,228				2.00
3.00	Total (sum of lines 1-2)	0	5,663,931				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet A-7
Part III
Date/Time Prepared:
8/19/2013 3:15 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	69,983,188	0	69,983,188	0.737123	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	24,957,825	0	24,957,825	0.262877	0	2.00
3.00	Total (sum of lines 1-2)	94,941,013	0	94,941,013	1.000000	0	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	3,752,183	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	4,579,800	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	8,331,983	0	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	3,752,183	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	4,579,800	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	8,331,983	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet A-8

Date/Time Prepared:
8/19/2013 3:15 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	-4,704,151				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	14,869,389				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-330,253	CAFETERIA		11.00	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	B	-47,680	MEDICAL RECORDS & LIBRARY		16.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts			0		0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist	A	-853,194	NONPHYSICIAN ANESTHETISTS		19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00		30.00
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 TELEVISION AND RADIO SERVICES	A	-582	CAP REL COSTS-MVBLE EQUIP		2.00	9	33.00
33.01 COMMUNITY DONATIONS	A	-20,000	EMERGENCY		91.00	0	33.01
34.00 INTEREST INCOME UNRESTRICTED	B	-209,365	OTHER ADMINISTRATIVE AND GENERAL		5.05	0	34.00

Provider CCN: 140011

Period:
 From 04/01/2012
 To 03/31/2013

Worksheet A-8

Date/Time Prepared:
 8/19/2013 3:15 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
35.00	PAYMENTS FOR OUTPATIENT SERVICES	B	-2,276,072	EMPLOYEE BENEFITS	4.00	0	35.00
36.00	NONALLOWABLE BOND EXPENSE	A	-1,915,482	INTEREST EXPENSE	113.00	0	36.00
37.00	PURCHASE DISCOUNTS	B	-10,740	PURCHASING RECEIVING AND STORES	5.03	0	37.00
38.00	CABLE TV	A	-1,024	SUBPROVIDER - IRF	41.00	0	38.00
39.00	OFFSET OF LOBBYING EXPENSES	A	-26,911	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	39.00
40.00	COMMUNITY DONATIONS	A	-9,650	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	40.00
41.00	LEASEHOLD REVENUE	B	-172,011	CAP REL COSTS-BLDG & FIXT	1.00	9	41.00
42.00	DEBT FORGIVENESS	A	-1,421,530	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	42.00
43.00	FUNDED DEPRECIATION	A	-1,425	CAP REL COSTS-BLDG & FIXT	1.00	9	43.00
44.00	REAL ESTATE TAXES	A	-74,239	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	44.00
45.00	MEDICAID PROVIDER TAX	A	-1,346,968	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	45.00
46.00	MISCELLANEOUS INCOME	B	-10,739	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	46.00
47.00	CABLE TV	A	-888	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	47.00
48.00	SALE OF XRAY SILVER	B	-1,499	RADIOLOGY-DIAGNOSTIC	54.00	0	48.00
49.00	XRAY FILM REVENUE	B	-1,011	RADIOLOGY-DIAGNOSTIC	54.00	0	49.00
49.01	LOSS ON 1987 BONDS	A	86,941	CAP REL COSTS-BLDG & FIXT	1.00	9	49.01
49.02	LOSS ON 1987 BONDS	A	10,254	CAP REL COSTS-MVBLE EQUIP	2.00	9	49.02
49.03	LOSS ON 1991 BONDS	A	140,760	CAP REL COSTS-BLDG & FIXT	1.00	9	49.03
49.04	LOSS ON 1991 BONDS	A	193,111	CAP REL COSTS-MVBLE EQUIP	2.00	9	49.04
49.05	PA SALARIES WOUND CARE	A	-3,698	CLINIC	90.00	0	49.05
49.06	PA EHW WOUND CARE	A	-1,295	EMPLOYEE BENEFITS	4.00	0	49.06
49.07	MISCELLANEOUS INCOME	B	-173	MAINTENANCE & REPAIRS	6.00	0	49.07
49.08	LEASEHOLD REVENUE	B	-17,934	CAP REL COSTS-MVBLE EQUIP	2.00	9	49.08
49.09	PERSONAL USE OF PROVIDER VEHICLES	A	-3,973	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	49.09
49.10	COMMUNITY DONATIONS	A	-35	ELECTROCARDIOLOGY	69.00	0	49.10
49.11	EKG MED DIR FEE POSTED TO MHC	A	275	ELECTROCARDIOLOGY	69.00	0	49.11
49.12	OVERPAYMENT TO DR. AHUJA	A	-4,800	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	49.12
49.13	OVERPAYMENT TO DR. ISTANBOULY	A	-2,340	INTENSIVE CARE UNIT	31.00	0	49.13
49.14			0		0.00	0	49.14
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,831,068				50.00

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

Provider CCN: 140011

Period: From 04/01/2012 To 03/31/2013

Worksheet A-8-1

Date/Time Prepared: 8/19/2013 3:15 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	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	94,862	0 1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	1,971,367	0 2.00
3.00	4.00	EMPLOYEE BENEFITS	HOME OFFICE	2,720,779	0 3.00
4.00	5.02	DATA PROCESSING	HOME OFFICE	3,115,140	0 4.00
4.01	5.04	CASHIERING/ACCOUNTS RECEIVABLE	HOME OFFICE	1,957,408	0 4.01
4.02	5.05	OTHER ADMINISTRATIVE AND GENERAL	HOME OFFICE	5,009,833	0 4.02
4.03	0.00			0	0 4.03
4.04	0.00			0	0 4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			14,869,389	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.

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

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

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

6.00	B	SIHS	100.00	SIHS	100.00	6.00
7.00	B	SIHE	100.00	SIHE	100.00	7.00
8.00	B	HSSI	100.00	HSSI	100.00	8.00
9.00	B	SIMS	100.00	SIMS	100.00	9.00
10.00	B	SIH CAYMAN	100.00	SIH CAYMAN	100.00	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: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet A-8-1

Date/Time Prepared:
8/19/2013 3:15 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	94,862	9		1.00
2.00	1,971,367	9		2.00
3.00	2,720,779	0		3.00
4.00	3,115,140	0		4.00
4.01	1,957,408	0		4.01
4.02	5,009,833	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
5.00	14,869,389			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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	HEALTHCARE		6.00
7.00	HEALTHCARE		7.00
8.00	HEALTHCARE		8.00
9.00	HEALTHCARE		9.00
10.00	CAPTIVE		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: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet A-8-2

Date/Time Prepared:
8/19/2013 3:15 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	60.00	DR. A	80,000	0	80,000	208,000	478	1.00
2.00	65.00	DR. B	15,505	0	15,505	159,800	124	2.00
3.00	69.00	DR. C	110,801	107,776	3,025	159,800	28	3.00
4.00	76.97	DR. D	4,635	0	4,635	159,800	42	4.00
5.00	91.00	DR. E	1,771,840	1,761,110	10,730	159,800	85	5.00
6.00	30.00	DR. F	1,453,151	1,453,151	0	0	0	6.00
7.00	41.00	DR. G	1,246,251	1,246,251	0	0	0	7.00
8.00	50.00	DR. H	102,179	40,342	61,837	182,900	351	8.00
9.00	31.00	DR. I	48,620	0	48,620	159,800	374	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,832,982	4,608,630	224,352		1,482	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	60.00	DR. A	47,800	2,390	0	0	0	1.00
2.00	65.00	DR. B	9,526	476	0	0	0	2.00
3.00	69.00	DR. C	2,151	108	0	0	0	3.00
4.00	76.97	DR. D	3,227	161	0	0	0	4.00
5.00	91.00	DR. E	6,530	327	0	0	0	5.00
6.00	30.00	DR. F	0	0	0	0	0	6.00
7.00	41.00	DR. G	0	0	0	0	0	7.00
8.00	50.00	DR. H	30,864	1,543	0	0	0	8.00
9.00	31.00	DR. I	28,733	1,437	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			128,831	6,442	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	60.00	DR. A	0	47,800	32,200	32,200	1.00
2.00	65.00	DR. B	0	9,526	5,979	5,979	2.00
3.00	69.00	DR. C	0	2,151	874	108,650	3.00
4.00	76.97	DR. D	0	3,227	1,408	1,408	4.00
5.00	91.00	DR. E	0	6,530	4,200	1,765,310	5.00
6.00	30.00	DR. F	0	0	0	1,453,151	6.00
7.00	41.00	DR. G	0	0	0	1,246,251	7.00
8.00	50.00	DR. H	0	30,864	30,973	71,315	8.00
9.00	31.00	DR. I	0	28,733	19,887	19,887	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	128,831	95,521	4,704,151	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140011

Period: From 04/01/2012 To 03/31/2013

Worksheet B Part I Date/Time Prepared: 8/19/2013 3:15 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	DATA PROCESSING	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.02	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	3,752,183	3,752,183			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	4,579,800		4,579,800		2.00
4.00 00400	EMPLOYEE BENEFITS	12,679,308	11,895	3,535	12,694,738	4.00
5.02 00520	DATA PROCESSING	3,115,140	18,947	0	0	3,134,087 5.02
5.03 00530	PURCHASING RECEIVING AND STORES	61,854	13,700	290	0	16,072 5.03
5.04 00550	CASHIERING/ACCOUNTS RECEIVABLE	2,713,271	27,738	8,464	260,110	112,506 5.04
5.05 00560	OTHER ADMINISTRATIVE AND GENERAL	11,925,630	738,528	83,490	1,288,637	278,586 5.05
6.00 00600	MAINTENANCE & REPAIRS	1,675,598	408,964	30,847	208,977	26,787 6.00
8.00 00800	LAUNDRY & LINEN SERVICE	448,164	0	0	14,720	0 8.00
9.00 00900	HOUSEKEEPING	1,112,115	61,971	31,868	310,022	26,787 9.00
10.00 01000	DIETARY	561,864	58,867	39,984	126,979	80,361 10.00
11.00 01100	CAFETERIA	671,121	71,977	0	226,306	0 11.00
13.00 01300	NURSING ADMINISTRATION	1,270,316	26,472	181,426	445,148	117,863 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	229,836	32,918	23,185	63,743	0 14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	321,909	0	17,876	129,356	101,791 16.00
17.00 01700	SOCIAL SERVICE	0	4,758	0	0	10,715 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	7,324,386	540,061	307,955	2,166,502	476,810 30.00
31.00 03100	INTENSIVE CARE UNIT	1,937,962	72,213	40,035	549,094	85,719 31.00
41.00 04100	SUBPROVIDER - I/R	3,203,513	324,097	95,239	922,638	530,383 41.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	4,387,003	259,578	946,533	990,979	166,080 50.00
51.00 05100	RECOVERY ROOM	279,895	19,217	7,051	92,045	0 51.00
53.00 05300	ANESTHESIOLOGY	162,311	0	49,256	8,709	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,459,396	166,899	700,966	709,450	155,365 54.00
56.00 05600	RADIOISOTOPE	1,394,837	26,759	244,157	121,606	26,787 56.00
57.00 05700	CT SCAN	882,133	17,210	304,771	181,890	10,715 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	402,345	7,238	545,982	88,832	5,357 58.00
60.00 06000	LABORATORY	4,369,691	143,515	269,726	527,922	112,506 60.00
65.00 06500	RESPIRATORY THERAPY	1,224,873	52,726	110,815	386,234	58,932 65.00
66.00 06600	PHYSICAL THERAPY	2,594,481	126,491	69,698	837,112	225,011 66.00
69.00 06900	ELECTROCARDIOLOGY	567,789	24,650	215,091	182,057	42,859 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,634,347	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	2,522,949	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	5,776,173	32,361	29,120	603,803	107,148 73.00
76.97 07697	CARDIAC REHABILITATION	403,671	27,164	13,479	140,985	91,076 76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	470,957	0	370	62,369	16,072 90.00
91.00 09100	EMERGENCY	3,843,357	246,469	191,775	1,048,513	192,867 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	92,960,178	3,563,383	4,562,984	12,694,738	3,075,155 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,101	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	79,357	8,116	16,816	0	58,932 192.00
192.01 19201	VACANT SPACE	0	165,583	0	0	0 192.01
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	93,039,535	3,752,183	4,579,800	12,694,738	3,134,087 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet B
Part I
Date/Time Prepared:
8/19/2013 3:15 pm

Cost Center Description			PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.03	5.04	5A.04	5.05	6.00	
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						4.00
5.02	00520	DATA PROCESSING						5.02
5.03	00530	PURCHASING RECEIVING AND STORES	91,916					5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE	399	3,122,488				5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	18	0	14,314,889	14,314,889		5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	2,351,173	427,526	2,778,699	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	462,884	84,169	0	8.00
9.00	00900	HOUSEKEEPING	16	0	1,542,779	280,531	67,998	9.00
10.00	01000	DIETARY	7	0	868,062	157,844	64,592	10.00
11.00	01100	CAFETERIA	13	0	969,417	176,274	78,977	11.00
13.00	01300	NURSING ADMINISTRATION	17	0	2,041,242	371,169	29,047	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	89	0	349,771	63,601	36,119	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	570,932	103,815	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	15,473	2,814	5,221	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	20,716	150,868	10,987,298	1,997,869	592,586	30.00
31.00	03100	INTENSIVE CARE UNIT	5,772	23,550	2,714,345	493,563	79,236	31.00
41.00	04100	SUBPROVIDER - IRF	3,210	122,902	5,201,982	945,902	355,617	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	34,616	376,450	7,161,239	1,302,164	284,823	50.00
51.00	05100	RECOVERY ROOM	660	24,259	423,127	76,939	21,086	51.00
53.00	05300	ANESTHESIOLOGY	2,970	42,312	265,558	48,288	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	990	188,988	4,382,054	796,811	183,131	54.00
56.00	05600	RADIOISOTOPE	282	170,576	1,985,004	360,943	29,362	56.00
57.00	05700	CT SCAN	2,468	378,026	1,777,213	323,160	18,883	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	129	110,039	1,159,922	210,914	7,942	58.00
60.00	06000	LABORATORY	3,093	556,286	5,982,739	1,087,871	157,472	60.00
65.00	06500	RESPIRATORY THERAPY	1,367	53,837	1,888,784	343,447	57,853	65.00
66.00	06600	PHYSICAL THERAPY	154	127,294	3,980,241	723,747	138,792	66.00
69.00	06900	ELECTROCARDIOLOGY	466	136,705	1,169,617	212,677	27,048	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	188,867	3,823,214	695,194	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,522,949	458,760	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,291	239,734	6,789,630	1,234,592	35,508	73.00
76.97	07697	CARDIAC REHABILITATION	127	13,384	689,886	125,445	29,806	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	736	15,782	566,286	102,971	0	90.00
91.00	09100	EMERGENCY	12,310	202,629	5,737,920	1,043,355	270,439	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	91,916	3,122,488	92,695,630	14,252,355	2,571,538	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	15,101	2,746	16,569	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	163,221	29,679	8,905	192.00
192.01	19201	VACANT SPACE	0	0	165,583	30,109	181,687	192.01
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	91,916	3,122,488	93,039,535	14,314,889	2,778,699	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet B
Part I
Date/Time Prepared:
8/19/2013 3:15 pm

Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
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					4.00
5.02	00520	DATA PROCESSING					5.02
5.03	00530	PURCHASING RECEIVING AND STORES					5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL					5.05
6.00	00600	MAINTENANCE & REPAIRS					6.00
8.00	00800	LAUNDRY & LINEN SERVICE	547,053				8.00
9.00	00900	HOUSEKEEPING	0	1,891,308			9.00
10.00	01000	DIETARY	0	45,067	1,135,565		10.00
11.00	01100	CAFETERIA	0	55,104	0	1,279,772	11.00
13.00	01300	NURSING ADMINISTRATION	0	20,267	0	55,530	2,517,255
14.00	01400	CENTRAL SERVICES & SUPPLY	0	25,201	0	7,952	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	16,137	0
17.00	01700	SOCIAL SERVICE	0	3,643	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	329,910	413,458	684,822	270,269	1,083,512
31.00	03100	INTENSIVE CARE UNIT	47,095	55,284	97,760	68,497	367,608
41.00	04100	SUBPROVIDER - I RF	170,048	248,121	352,983	115,095	150,857
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	198,727	0	123,621	27,758
51.00	05100	RECOVERY ROOM	0	14,712	0	11,482	12,310
53.00	05300	ANESTHESIOLOGY	0	0	0	1,086	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	127,774	0	88,501	0
56.00	05600	RADIOISOTOPE	0	20,486	0	15,170	0
57.00	05700	CT SCAN	0	13,175	0	22,690	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	5,541	0	11,081	0
60.00	06000	LABORATORY	0	109,871	0	65,856	0
65.00	06500	RESPIRATORY THERAPY	0	40,365	0	48,181	0
66.00	06600	PHYSICAL THERAPY	0	96,838	0	104,426	0
69.00	06900	ELECTROCARDIOLOGY	0	18,872	0	22,711	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	24,775	0	75,322	28,723
76.97	07697	CARDIAC REHABILITATION	0	20,796	0	17,587	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	7,780	0
91.00	09100	EMERGENCY	0	188,690	0	130,798	846,487
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	547,053	1,746,767	1,135,565	1,279,772	2,517,255
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,561	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,213	0	0	0
192.01	19201	VACANT SPACE	0	126,767	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	547,053	1,891,308	1,135,565	1,279,772	2,517,255

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet B
Part I
Date/Time Prepared:
8/19/2013 3:15 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
		14.00	16.00	17.00	19.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.02	00520						5.02
5.03	00530						5.03
5.04	00550						5.04
5.05	00560						5.05
6.00	00600						6.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400	482,644					14.00
16.00	01600	0	690,884				16.00
17.00	01700	0	0	27,151			17.00
19.00	01900	0	0	0	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	331	33,387	16,374	0	16,409,816	30.00
31.00	03100	467	5,212	2,337	0	3,931,404	31.00
41.00	04100	26	27,198	8,440	0	7,576,269	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	421,768	83,309	0	0	9,603,409	50.00
51.00	05100	7	5,368	0	0	565,031	51.00
53.00	05300	3,657	9,364	0	0	327,953	53.00
54.00	05400	2,198	41,823	0	0	5,622,292	54.00
56.00	05600	0	37,749	0	0	2,448,714	56.00
57.00	05700	136	83,658	0	0	2,238,915	57.00
58.00	05800	205	24,352	0	0	1,419,957	58.00
60.00	06000	46,811	122,981	0	0	7,573,601	60.00
65.00	06500	5,873	11,914	0	0	2,396,417	65.00
66.00	06600	0	28,170	0	0	5,072,214	66.00
69.00	06900	20	30,253	0	0	1,481,198	69.00
71.00	07100	179	41,796	0	0	4,560,383	71.00
72.00	07200	0	0	0	0	2,981,709	72.00
73.00	07300	70	53,053	0	0	8,241,673	73.00
76.97	07697	0	2,962	0	0	886,482	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	492	3,493	0	0	681,022	90.00
91.00	09100	404	44,842	0	0	8,262,935	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		482,644	690,884	27,151	0	92,281,394	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	45,977	190.00
192.00	19200	0	0	0	0	208,018	192.00
192.01	19201	0	0	0	0	504,146	192.01
200.00						0	200.00
201.00		0	0	0	0	0	201.00
202.00		482,644	690,884	27,151	0	93,039,535	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet B
Part I
Date/Time Prepared:
8/19/2013 3:15 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		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		4.00
5.02	00520	DATA PROCESSING		5.02
5.03	00530	PURCHASING RECEIVING AND STORES		5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE		5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL		5.05
6.00	00600	MAINTENANCE & REPAIRS		6.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	16,409,816
31.00	03100	INTENSIVE CARE UNIT	0	3,931,404
41.00	04100	SUBPROVIDER - I RF	0	7,576,269
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	9,603,409
51.00	05100	RECOVERY ROOM	0	565,031
53.00	05300	ANESTHESIOLOGY	0	327,953
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,622,292
56.00	05600	RADIOISOTOPE	0	2,448,714
57.00	05700	CT SCAN	0	2,238,915
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,419,957
60.00	06000	LABORATORY	0	7,573,601
65.00	06500	RESPIRATORY THERAPY	0	2,396,417
66.00	06600	PHYSICAL THERAPY	0	5,072,214
69.00	06900	ELECTROCARDIOLOGY	0	1,481,198
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,560,383
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,981,709
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,241,673
76.97	07697	CARDIAC REHABILITATION	0	886,482
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	681,022
91.00	09100	EMERGENCY	0	8,262,935
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	92,281,394
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	45,977
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	208,018
192.01	19201	VACANT SPACE	0	504,146
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	93,039,535

COST ALLOCATION STATISTICS

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet Non-CMS W

Date/Time Prepared:
8/19/2013 3:15 pm

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS	3	GROSS SALARIES	4.00
5.02	DATA PROCESSING	5	NUMBER OF PCS	5.02
5.03	PURCHASING RECEIVING AND STORES	6	PURCHASING SUPPLIES	5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE	7	GROSS REVENUE	5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL	-5	ACCUM. COST	5.05
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
8.00	LAUNDRY & LINEN SERVICE	8	PATIENT DAYS	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	9	MEALS SERVED	10.00
11.00	CAFETERIA	3	GROSS SALARIES	11.00
13.00	NURSING ADMINISTRATION	10	MEALS SERVED	13.00
14.00	CENTRAL SERVICES & SUPPLY	11	COSTED REQUIS.	14.00
16.00	MEDICAL RECORDS & LIBRARY	7	GROSS REVENUE	16.00
17.00	SOCIAL SERVICE	8	PATIENT DAYS	17.00
19.00	NONPHYSICIAN ANESTHETISTS	12	NUMBER HOUSED	19.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140011

Period: From 04/01/2012 To 03/31/2013

Worksheet B Part II Date/Time Prepared: 8/19/2013 3:15 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
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	0	11,895	3,535	15,430	4.00
5.02 00520	DATA PROCESSING	0	18,947	0	18,947	5.02
5.03 00530	PURCHASING RECEIVING AND STORES	0	13,700	290	13,990	5.03
5.04 00550	CASHIERING/ACCOUNTS RECEIVABLE	0	27,738	8,464	36,202	5.04
5.05 00560	OTHER ADMINISTRATIVE AND GENERAL	0	738,528	83,490	822,018	5.05
6.00 00600	MAINTENANCE & REPAIRS	0	408,964	30,847	439,811	6.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	61,971	31,868	93,839	9.00
10.00 01000	DIETARY	0	58,867	39,984	98,851	10.00
11.00 01100	CAFETERIA	0	71,977	0	71,977	11.00
13.00 01300	NURSING ADMINISTRATION	0	26,472	181,426	207,898	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	32,918	23,185	56,103	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	17,876	17,876	16.00
17.00 01700	SOCIAL SERVICE	0	4,758	0	4,758	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	540,061	307,955	848,016	30.00
31.00 03100	INTENSIVE CARE UNIT	0	72,213	40,035	112,248	31.00
41.00 04100	SUBPROVIDER - IRF	0	324,097	95,239	419,336	41.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	259,578	946,533	1,206,111	50.00
51.00 05100	RECOVERY ROOM	0	19,217	7,051	26,268	51.00
53.00 05300	ANESTHESIOLOGY	0	0	49,256	49,256	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	166,899	700,966	867,865	54.00
56.00 05600	RADIOISOTOPE	0	26,759	244,157	270,916	56.00
57.00 05700	CT SCAN	0	17,210	304,771	321,981	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	7,238	545,982	553,220	58.00
60.00 06000	LABORATORY	0	143,515	269,726	413,241	60.00
65.00 06500	RESPIRATORY THERAPY	0	52,726	110,815	163,541	65.00
66.00 06600	PHYSICAL THERAPY	0	126,491	69,698	196,189	66.00
69.00 06900	ELECTROCARDIOLOGY	0	24,650	215,091	239,741	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	32,361	29,120	61,481	73.00
76.97 07697	CARDIAC REHABILITATION	0	27,164	13,479	40,643	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	370	370	90.00
91.00 09100	EMERGENCY	0	246,469	191,775	438,244	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	3,563,383	4,562,984	8,126,367	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,101	0	15,101	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	8,116	16,816	24,932	192.00
192.01 19201	VACANT SPACE	0	165,583	0	165,583	192.01
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	3,752,183	4,579,800	8,331,983	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet B
Part II
Date/Time Prepared:
8/19/2013 3:15 pm

Cost Center Description		DATA PROCESSING	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
		5.02	5.03	5.04	5.05	6.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.02	00520	18,947					5.02
5.03	00530	97	14,087				5.03
5.04	00550	680	61	37,259			5.04
5.05	00560	1,684	3	0	825,272		5.05
6.00	00600	162	0	0	24,647	464,874	6.00
8.00	00800	0	0	0	4,852	0	8.00
9.00	00900	162	2	0	16,173	11,376	9.00
10.00	01000	486	1	0	9,100	10,806	10.00
11.00	01100	0	2	0	10,162	13,213	11.00
13.00	01300	713	3	0	21,398	4,860	13.00
14.00	01400	0	14	0	3,667	6,043	14.00
16.00	01600	615	0	0	5,985	0	16.00
17.00	01700	65	0	0	162	873	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,883	3,175	1,797	115,183	99,138	30.00
31.00	03100	518	885	281	28,454	13,256	31.00
41.00	04100	3,207	492	1,464	54,532	59,494	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,004	5,305	4,484	75,071	47,651	50.00
51.00	05100	0	101	289	4,436	3,528	51.00
53.00	05300	0	455	504	2,784	0	53.00
54.00	05400	939	152	2,251	45,937	30,638	54.00
56.00	05600	162	43	2,032	20,809	4,912	56.00
57.00	05700	65	378	4,503	18,631	3,159	57.00
58.00	05800	32	20	1,311	12,159	1,329	58.00
60.00	06000	680	474	6,691	62,717	26,345	60.00
65.00	06500	356	209	641	19,800	9,679	65.00
66.00	06600	1,360	24	1,516	41,725	23,220	66.00
69.00	06900	259	71	1,628	12,261	4,525	69.00
71.00	07100	0	0	2,250	40,079	0	71.00
72.00	07200	0	0	0	26,448	0	72.00
73.00	07300	648	198	2,856	71,176	5,940	73.00
76.97	07697	551	19	159	7,232	4,987	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	97	113	188	5,936	0	90.00
91.00	09100	1,166	1,887	2,414	60,151	45,244	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		18,591	14,087	37,259	821,667	430,216	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	158	2,772	190.00
192.00	19200	356	0	0	1,711	1,490	192.00
192.01	19201	0	0	0	1,736	30,396	192.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		18,947	14,087	37,259	825,272	464,874	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet B
Part II
Date/Time Prepared:
8/19/2013 3:15 pm

Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.02	00520						5.02
5.03	00530						5.03
5.04	00550						5.04
5.05	00560						5.05
6.00	00600						6.00
8.00	00800	4,870					8.00
9.00	00900	0	121,929				9.00
10.00	01000	0	2,905	122,303			10.00
11.00	01100	0	3,552	0	99,181		11.00
13.00	01300	0	1,307	0	4,303	241,023	13.00
14.00	01400	0	1,625	0	616	0	14.00
16.00	01600	0	0	0	1,250	0	16.00
17.00	01700	0	235	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,937	26,655	73,757	20,952	103,744	30.00
31.00	03100	419	3,564	10,529	5,308	35,198	31.00
41.00	04100	1,514	15,996	38,017	8,919	14,444	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	12,812	0	9,580	2,658	50.00
51.00	05100	0	948	0	890	1,179	51.00
53.00	05300	0	0	0	84	0	53.00
54.00	05400	0	8,237	0	6,858	0	54.00
56.00	05600	0	1,321	0	1,176	0	56.00
57.00	05700	0	849	0	1,758	0	57.00
58.00	05800	0	357	0	859	0	58.00
60.00	06000	0	7,083	0	5,103	0	60.00
65.00	06500	0	2,602	0	3,734	0	65.00
66.00	06600	0	6,243	0	8,092	0	66.00
69.00	06900	0	1,217	0	1,760	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	1,597	0	5,837	2,750	73.00
76.97	07697	0	1,341	0	1,363	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	603	0	90.00
91.00	09100	0	12,165	0	10,136	81,050	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		4,870	112,611	122,303	99,181	241,023	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	745	0	0	0	190.00
192.00	19200	0	401	0	0	0	192.00
192.01	19201	0	8,172	0	0	0	192.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		4,870	121,929	122,303	99,181	241,023	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140011		Period: From 04/01/2012 To 03/31/2013		Worksheet B Part II Date/Time Prepared: 8/19/2013 3:15 pm	
Cost Center Description			CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			14.00	16.00	17.00	19.00	24.00	
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						4.00
5.02	00520	DATA PROCESSING						5.02
5.03	00530	PURCHASING RECEIVING AND STORES						5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	68,146					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	25,883				16.00
17.00	01700	SOCIAL SERVICE	0	0	6,093			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	47	1,251	3,674		1,305,837	30.00
31.00	03100	INTENSIVE CARE UNIT	66	195	525		212,114	31.00
41.00	04100	SUBPROVIDER - IRF	4	1,019	1,894		621,454	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	59,551	3,121	0		1,428,553	50.00
51.00	05100	RECOVERY ROOM	1	201	0		37,953	51.00
53.00	05300	ANESTHESIOLOGY	516	351	0		53,961	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	310	1,567	0		965,617	54.00
56.00	05600	RADIOISOTOPE	0	1,414	0		302,933	56.00
57.00	05700	CT SCAN	19	3,134	0		354,698	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	29	912	0		570,336	58.00
60.00	06000	LABORATORY	6,609	4,608	0		534,193	60.00
65.00	06500	RESPIRATORY THERAPY	829	446	0		202,307	65.00
66.00	06600	PHYSICAL THERAPY	0	1,055	0		280,442	66.00
69.00	06900	ELECTROCARDIOLOGY	3	1,133	0		262,819	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25	1,566	0		43,920	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		26,448	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10	1,988	0		155,215	73.00
76.97	07697	CARDIAC REHABILITATION	0	111	0		56,577	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	70	131	0		7,584	90.00
91.00	09100	EMERGENCY	57	1,680	0		655,469	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	68,146	25,883	6,093	0	8,078,430	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		18,776	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		28,890	192.00
192.01	19201	VACANT SPACE	0	0	0		205,887	192.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	68,146	25,883	6,093	0	8,331,983	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140011	Period: From 04/01/2012 To 03/31/2013	Worksheet B Part II Date/Time Prepared: 8/19/2013 3:15 pm
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		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		4.00
5.02	00520	DATA PROCESSING		5.02
5.03	00530	PURCHASING RECEIVING AND STORES		5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE		5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL		5.05
6.00	00600	MAINTENANCE & REPAIRS		6.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,305,837
31.00	03100	INTENSIVE CARE UNIT	0	212,114
41.00	04100	SUBPROVIDER - I RF	0	621,454
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,428,553
51.00	05100	RECOVERY ROOM	0	37,953
53.00	05300	ANESTHESIOLOGY	0	53,961
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	965,617
56.00	05600	RADIOISOTOPE	0	302,933
57.00	05700	CT SCAN	0	354,698
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	570,336
60.00	06000	LABORATORY	0	534,193
65.00	06500	RESPIRATORY THERAPY	0	202,307
66.00	06600	PHYSICAL THERAPY	0	280,442
69.00	06900	ELECTROCARDIOLOGY	0	262,819
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	43,920
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	26,448
73.00	07300	DRUGS CHARGED TO PATIENTS	0	155,215
76.97	07697	CARDIAC REHABILITATION	0	56,577
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	7,584
91.00	09100	EMERGENCY	0	655,469
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	8,078,430
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,776
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	28,890
192.01	19201	VACANT SPACE	0	205,887
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	8,331,983

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet B-1

Date/Time Prepared:
8/19/2013 3:15 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	DATA PROCESSING (NUMBER OF PCS)	PURCHASING RECEIVING AND STORES (PURCHASING SUPPLIES)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	222,389				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		2,317,614			2.00
4.00 00400	EMPLOYEE BENEFITS	705	1,789	33,778,744		4.00
5.02 00520	DATA PROCESSING	1,123	0	0	585	5.02
5.03 00530	PURCHASING RECEIVING AND STORES	812	147	0	3	3,718,646
5.04 00550	CASHIERING/ACCOUNTS RECEIVABLE	1,644	4,283	692,112	21	16,146
5.05 00560	OTHER ADMINISTRATIVE AND GENERAL	43,772	42,250	3,428,868	52	722
6.00 00600	MAINTENANCE & REPAIRS	24,239	15,610	556,056	5	0
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	39,169	0	0
9.00 00900	HOUSEKEEPING	3,673	16,127	824,921	5	643
10.00 01000	DIETARY	3,489	20,234	337,871	15	298
11.00 01100	CAFETERIA	4,266	0	602,167	0	531
13.00 01300	NURSING ADMINISTRATION	1,569	91,811	1,184,472	22	682
14.00 01400	CENTRAL SERVICES & SUPPLY	1,951	11,733	169,611	0	3,596
16.00 01600	MEDICAL RECORDS & LIBRARY	0	9,046	344,197	19	5
17.00 01700	SOCIAL SERVICE	282	0	0	2	0
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	32,009	155,841	5,764,700	89	838,113
31.00 03100	INTENSIVE CARE UNIT	4,280	20,260	1,461,057	16	233,516
41.00 04100	SUBPROVIDER - I/R	19,209	48,196	2,454,999	99	129,866
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	15,385	478,994	2,636,846	31	1,400,495
51.00 05100	RECOVERY ROOM	1,139	3,568	244,919	0	26,702
53.00 05300	ANESTHESIOLOGY	0	24,926	23,172	0	120,157
54.00 05400	RADIOLOGY-DIAGNOSTIC	9,892	354,725	1,887,739	29	40,035
56.00 05600	RADIOISOTOPE	1,586	123,556	323,574	5	11,396
57.00 05700	CT SCAN	1,020	154,230	483,983	2	99,862
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	429	276,295	236,369	1	5,210
60.00 06000	LABORATORY	8,506	136,495	1,404,721	21	125,133
65.00 06500	RESPIRATORY THERAPY	3,125	56,078	1,027,711	11	55,296
66.00 06600	PHYSICAL THERAPY	7,497	35,271	2,227,429	42	6,236
69.00 06900	ELECTROCARDIOLOGY	1,461	108,847	484,426	8	18,841
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	1,918	14,736	1,606,627	20	52,230
76.97 07697	CARDIAC REHABILITATION	1,610	6,821	375,140	17	5,126
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	187	165,954	3	29,756
91.00 09100	EMERGENCY	14,608	97,048	2,789,934	36	498,033
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	211,199	2,309,104	33,778,744	574	3,718,626
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	895	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	481	8,510	0	11	20
192.01 19201	VACANT SPACE	9,814	0	0	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	3,752,183	4,579,800	12,694,738	3,134,087	91,916
203.00	Unit cost multiplier (Wkst. B, Part I)	16.872161	1.976084	0.375820	5,357.413675	0.024718
204.00	Cost to be allocated (per Wkst. B, Part II)			15,430	18,947	14,087
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000457	32.388034	0.003788

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140011

Period: From 04/01/2012 To 03/31/2013

Worksheet B-1

Date/Time Prepared: 8/19/2013 3:15 pm

Cost Center Description		CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	
		5.04	5A.05	5.05	6.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.02	00520						5.02
5.03	00530						5.03
5.04	00550						5.04
5.05	00560	364,643,812	-14,314,889	78,724,646			5.05
6.00	00600	0	0	2,351,173	150,094		6.00
8.00	00800	0	0	462,884	0	24,707	8.00
9.00	00900	0	0	1,542,779	3,673	0	9.00
10.00	01000	0	0	868,062	3,489	0	10.00
11.00	01100	0	0	969,417	4,266	0	11.00
13.00	01300	0	0	2,041,242	1,569	0	13.00
14.00	01400	0	0	349,771	1,951	0	14.00
16.00	01600	0	0	570,932	0	0	16.00
17.00	01700	0	0	15,473	282	0	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	17,618,607	0	10,987,298	32,009	14,900	30.00
31.00	03100	2,750,172	0	2,714,345	4,280	2,127	31.00
41.00	04100	14,352,700	0	5,201,982	19,209	7,680	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	43,962,419	0	7,161,239	15,385	0	50.00
51.00	05100	2,832,976	0	423,127	1,139	0	51.00
53.00	05300	4,941,310	0	265,558	0	0	53.00
54.00	05400	22,070,257	0	4,382,054	9,892	0	54.00
56.00	05600	19,920,095	0	1,985,004	1,586	0	56.00
57.00	05700	44,146,489	0	1,777,213	1,020	0	57.00
58.00	05800	12,850,518	0	1,159,922	429	0	58.00
60.00	06000	64,958,871	0	5,982,739	8,506	0	60.00
65.00	06500	6,287,149	0	1,888,784	3,125	0	65.00
66.00	06600	14,865,639	0	3,980,241	7,497	0	66.00
69.00	06900	15,964,580	0	1,169,617	1,461	0	69.00
71.00	07100	22,056,195	0	3,823,214	0	0	71.00
72.00	07200	0	0	2,522,949	0	0	72.00
73.00	07300	27,996,469	0	6,789,630	1,918	0	73.00
76.97	07697	1,562,995	0	689,886	1,610	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	1,843,048	0	566,286	0	0	90.00
91.00	09100	23,663,323	0	5,737,920	14,608	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		364,643,812	-14,314,889	78,380,741	138,904	24,707	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	15,101	895	0	190.00
192.00	19200	0	0	163,221	481	0	192.00
192.01	19201	0	0	165,583	9,814	0	192.01
200.00							200.00
201.00							201.00
202.00		3,122,488		14,314,889	2,778,699	547,053	202.00
203.00		0.008563		0.181835	18.513058	22.141620	203.00
204.00		37,259		825,272	464,874	4,870	204.00
205.00		0.000102		0.010483	3.097219	0.197110	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet B-1

Date/Time Prepared:
8/19/2013 3:15 pm

Cost Center Description		HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (MEALS SERVED)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.02	00520						5.02
5.03	00530						5.03
5.04	00550						5.04
5.05	00560						5.05
6.00	00600						6.00
8.00	00800						8.00
9.00	00900	146,421					9.00
10.00	01000	3,489	74,121				10.00
11.00	01100	4,266	0	27,297,580			11.00
13.00	01300	1,569	0	1,184,472	52,145		13.00
14.00	01400	1,951	0	169,611	0	6,831,639	14.00
16.00	01600	0	0	344,197	0	0	16.00
17.00	01700	282	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	32,009	44,700	5,764,700	22,445	4,691	30.00
31.00	03100	4,280	6,381	1,461,057	7,615	6,617	31.00
41.00	04100	19,209	23,040	2,454,999	3,125	371	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	15,385	0	2,636,846	575	5,969,928	50.00
51.00	05100	1,139	0	244,919	255	99	51.00
53.00	05300	0	0	23,172	0	51,767	53.00
54.00	05400	9,892	0	1,887,739	0	31,115	54.00
56.00	05600	1,586	0	323,574	0	0	56.00
57.00	05700	1,020	0	483,983	0	1,920	57.00
58.00	05800	429	0	236,369	0	2,900	58.00
60.00	06000	8,506	0	1,404,721	0	662,596	60.00
65.00	06500	3,125	0	1,027,711	0	83,129	65.00
66.00	06600	7,497	0	2,227,429	0	0	66.00
69.00	06900	1,461	0	484,426	0	286	69.00
71.00	07100	0	0	0	0	2,538	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	1,918	0	1,606,627	595	992	73.00
76.97	07697	1,610	0	375,140	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	165,954	0	6,970	90.00
91.00	09100	14,608	0	2,789,934	17,535	5,720	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		135,231	74,121	27,297,580	52,145	6,831,639	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	895	0	0	0	0	190.00
192.00	19200	481	0	0	0	0	192.00
192.01	19201	9,814	0	0	0	0	192.01
200.00							200.00
201.00							201.00
202.00		1,891,308	1,135,565	1,279,772	2,517,255	482,644	202.00
203.00		12.916918	15.320422	0.046882	48.274139	0.070648	203.00
204.00		121,929	122,303	99,181	241,023	68,146	204.00
205.00		0.832729	1.650045	0.003633	4.622169	0.009975	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet B-1
Date/Time Prepared:
8/19/2013 3:15 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (NUMBER HOUSED)	
		16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.02	00520				5.02
5.03	00530				5.03
5.04	00550				5.04
5.05	00560				5.05
6.00	00600				6.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
16.00	01600	364,643,812			16.00
17.00	01700	0	24,707		17.00
19.00	01900	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	17,618,607	14,900		30.00
31.00	03100	2,750,172	2,127		31.00
41.00	04100	14,352,700	7,680		41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	43,962,419	0	0	50.00
51.00	05100	2,832,976	0	0	51.00
53.00	05300	4,941,310	0	0	53.00
54.00	05400	22,070,257	0	0	54.00
56.00	05600	19,920,095	0	0	56.00
57.00	05700	44,146,489	0	0	57.00
58.00	05800	12,850,518	0	0	58.00
60.00	06000	64,958,871	0	0	60.00
65.00	06500	6,287,149	0	0	65.00
66.00	06600	14,865,639	0	0	66.00
69.00	06900	15,964,580	0	0	69.00
71.00	07100	22,056,195	0	0	71.00
72.00	07200	0	0	0	72.00
73.00	07300	27,996,469	0	0	73.00
76.97	07697	1,562,995	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	1,843,048	0	0	90.00
91.00	09100	23,663,323	0	0	91.00
92.00	09200				92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		364,643,812	24,707	0	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	0	0	0	190.00
192.00	19200	0	0	0	192.00
192.01	19201	0	0	0	192.01
200.00					200.00
201.00					201.00
202.00		690,884	27,151	0	202.00
203.00		0.001895	1.098919	0.000000	203.00
204.00		25,883	6,093	0	204.00
205.00		0.000071	0.246610	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet C
Part I
Date/Time Prepared:
8/19/2013 3:15 pm

		Title XVIII		Hospital		PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	16,409,816	16,409,816	0	16,409,816	30.00
31.00	03100 INTENSIVE CARE UNIT	3,931,404	3,931,404	19,887	3,951,291	31.00
41.00	04100 SUBPROVIDER - I RF	7,576,269	7,576,269	0	7,576,269	41.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	9,603,409	9,603,409	30,973	9,634,382	50.00
51.00	05100 RECOVERY ROOM	565,031	565,031	0	565,031	51.00
53.00	05300 ANESTHESIOLOGY	327,953	327,953	0	327,953	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,622,292	5,622,292	0	5,622,292	54.00
56.00	05600 RADIOISOTOPE	2,448,714	2,448,714	0	2,448,714	56.00
57.00	05700 CT SCAN	2,238,915	2,238,915	0	2,238,915	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,419,957	1,419,957	0	1,419,957	58.00
60.00	06000 LABORATORY	7,573,601	7,573,601	32,200	7,605,801	60.00
65.00	06500 RESPIRATORY THERAPY	2,396,417	2,396,417	5,979	2,402,396	65.00
66.00	06600 PHYSICAL THERAPY	5,072,214	5,072,214	0	5,072,214	66.00
69.00	06900 ELECTROCARDIOLOGY	1,481,198	1,481,198	874	1,482,072	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,560,383	4,560,383	0	4,560,383	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2,981,709	2,981,709	0	2,981,709	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8,241,673	8,241,673	0	8,241,673	73.00
76.97	07697 CARDIAC REHABILITATION	886,482	886,482	1,408	887,890	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	681,022	681,022	0	681,022	90.00
91.00	09100 EMERGENCY	8,262,935	8,262,935	4,200	8,267,135	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,730,370	2,730,370	0	2,730,370	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	95,011,764	95,011,764	95,521	95,107,285	200.00
201.00	Less Observation Beds	2,730,370	2,730,370	0	2,730,370	201.00
202.00	Total (see instructions)	92,281,394	92,281,394	95,521	92,376,915	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet C
Part I
Date/Time Prepared:
8/19/2013 3:15 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,295,655		13,295,655		30.00
31.00	03100	INTENSIVE CARE UNIT	2,750,172		2,750,172		31.00
41.00	04100	SUBPROVIDER - IRF	12,819,899		12,819,899		41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	18,436,726	25,058,726	43,495,452	0.220791	50.00
51.00	05100	RECOVERY ROOM	1,605,252	1,068,925	2,674,177	0.211292	51.00
53.00	05300	ANESTHESIOLOGY	2,560,583	2,341,113	4,901,696	0.066906	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,350,164	18,391,181	21,741,345	0.258599	54.00
56.00	05600	RADIOISOTOPE	1,953,906	17,729,187	19,683,093	0.124407	56.00
57.00	05700	CT SCAN	9,302,003	34,437,232	43,739,235	0.051188	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,092,251	11,527,286	12,619,537	0.112521	58.00
60.00	06000	LABORATORY	18,312,753	45,580,996	63,893,749	0.118534	60.00
65.00	06500	RESPIRATORY THERAPY	4,785,183	1,481,963	6,267,146	0.382378	65.00
66.00	06600	PHYSICAL THERAPY	7,461,371	7,079,190	14,540,561	0.348832	66.00
69.00	06900	ELECTROCARDIOLOGY	4,257,564	10,552,799	14,810,363	0.100011	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,737,663	5,036,530	12,774,193	0.357000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,976,847	2,134,996	9,111,843	0.327234	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,652,376	9,215,916	27,868,292	0.295737	73.00
76.97	07697	CARDIAC REHABILITATION	2,069	1,542,878	1,544,947	0.573794	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	13,117	1,818,447	1,831,564	0.371825	90.00
91.00	09100	EMERGENCY	4,436,964	19,046,892	23,483,856	0.351856	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	71,038	4,227,948	4,298,986	0.635120	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	139,873,556	218,272,205	358,145,761		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	139,873,556	218,272,205	358,145,761		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet C
Part I
Date/Time Prepared:
8/19/2013 3:15 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
41.00	04100 SUBPROVIDER - IRF				41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.221503			50.00
51.00	05100 RECOVERY ROOM	0.211292			51.00
53.00	05300 ANESTHESIOLOGY	0.066906			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.258599			54.00
56.00	05600 RADIOISOTOPE	0.124407			56.00
57.00	05700 CT SCAN	0.051188			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.112521			58.00
60.00	06000 LABORATORY	0.119038			60.00
65.00	06500 RESPIRATORY THERAPY	0.383332			65.00
66.00	06600 PHYSICAL THERAPY	0.348832			66.00
69.00	06900 ELECTROCARDIOLOGY	0.100070			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.357000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.327234			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.295737			73.00
76.97	07697 CARDIAC REHABILITATION	0.574706			76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.371825			90.00
91.00	09100 EMERGENCY	0.352035			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.635120			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet C
Part I
Date/Time Prepared:
8/19/2013 3:15 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	16,409,816		16,409,816	0	0 30.00
31.00	03100 INTENSIVE CARE UNIT	3,931,404		3,931,404	0	0 31.00
41.00	04100 SUBPROVIDER - I RF	7,576,269		7,576,269	0	0 41.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	9,603,409		9,603,409	0	0 50.00
51.00	05100 RECOVERY ROOM	565,031		565,031	0	0 51.00
53.00	05300 ANESTHESIOLOGY	327,953		327,953	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,622,292		5,622,292	0	0 54.00
56.00	05600 RADIOISOTOPE	2,448,714		2,448,714	0	0 56.00
57.00	05700 CT SCAN	2,238,915		2,238,915	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,419,957		1,419,957	0	0 58.00
60.00	06000 LABORATORY	7,573,601		7,573,601	0	0 60.00
65.00	06500 RESPIRATORY THERAPY	2,396,417	0	2,396,417	0	0 65.00
66.00	06600 PHYSICAL THERAPY	5,072,214	0	5,072,214	0	0 66.00
69.00	06900 ELECTROCARDIOLOGY	1,481,198		1,481,198	0	0 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,560,383		4,560,383	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2,981,709		2,981,709	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8,241,673		8,241,673	0	0 73.00
76.97	07697 CARDIAC REHABILITATION	886,482		886,482	0	0 76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	681,022		681,022	0	0 90.00
91.00	09100 EMERGENCY	8,262,935		8,262,935	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,730,370		2,730,370	0	0 92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	95,011,764	0	95,011,764	0	0 200.00
201.00	Less Observation Beds	2,730,370		2,730,370		0 201.00
202.00	Total (see instructions)	92,281,394	0	92,281,394	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet C
Part I
Date/Time Prepared:
8/19/2013 3:15 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	13,295,655		13,295,655			30.00
31.00	03100 INTENSIVE CARE UNIT	2,750,172		2,750,172			31.00
41.00	04100 SUBPROVIDER - IRF	12,819,899		12,819,899			41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	18,436,726	25,058,726	43,495,452	0.220791	0.000000	50.00
51.00	05100 RECOVERY ROOM	1,605,252	1,068,925	2,674,177	0.211292	0.000000	51.00
53.00	05300 ANESTHESIOLOGY	2,560,583	2,341,113	4,901,696	0.066906	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,350,164	18,391,181	21,741,345	0.258599	0.000000	54.00
56.00	05600 RADIOISOTOPE	1,953,906	17,729,187	19,683,093	0.124407	0.000000	56.00
57.00	05700 CT SCAN	9,302,003	34,437,232	43,739,235	0.051188	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,092,251	11,527,286	12,619,537	0.112521	0.000000	58.00
60.00	06000 LABORATORY	18,312,753	45,580,996	63,893,749	0.118534	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	4,785,183	1,481,963	6,267,146	0.382378	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	7,461,371	7,079,190	14,540,561	0.348832	0.000000	66.00
69.00	06900 ELECTROCARDIOLOGY	4,257,564	10,552,799	14,810,363	0.100011	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7,737,663	5,036,530	12,774,193	0.357000	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	6,976,847	2,134,996	9,111,843	0.327234	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	18,652,376	9,215,916	27,868,292	0.295737	0.000000	73.00
76.97	07697 CARDIAC REHABILITATION	2,069	1,542,878	1,544,947	0.573794	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	13,117	1,818,447	1,831,564	0.371825	0.000000	90.00
91.00	09100 EMERGENCY	4,436,964	19,046,892	23,483,856	0.351856	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	71,038	4,227,948	4,298,986	0.635120	0.000000	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	139,873,556	218,272,205	358,145,761			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	139,873,556	218,272,205	358,145,761			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet C
Part I
Date/Time Prepared:
8/19/2013 3:15 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
41.00	04100 SUBPROVIDER - IRF				41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	05600 RADIOISOTOPE	0.000000			56.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140011		Period: From 04/01/2012 To 03/31/2013		Worksheet D Part I Date/Time Prepared: 8/19/2013 3:15 pm		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
Title XVIII Hospital PPS								
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	1,305,837	0	1,305,837	17,874	73.06	30.00	
31.00	INTENSIVE CARE UNIT	212,114		212,114	2,127	99.72	31.00	
41.00	SUBPROVIDER - IRF	621,454	0	621,454	7,680	80.92	41.00	
200.00	Total (Lines 30-199)	2,139,405		2,139,405	27,681		200.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	10,430	762,016					30.00
31.00	INTENSIVE CARE UNIT	1,263	125,946					31.00
41.00	SUBPROVIDER - IRF	5,581	451,615					41.00
200.00	Total (Lines 30-199)	17,274	1,339,577					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140011	Period: From 04/01/2012 To 03/31/2013	Worksheet D Part II Date/Time Prepared: 8/19/2013 3:15 pm
		Title XVIII	Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,428,553	43,495,452	0.032844	9,534,935	313,165	50.00
51.00	05100 RECOVERY ROOM	37,953	2,674,177	0.014192	795,324	11,287	51.00
53.00	05300 ANESTHESIOLOGY	53,961	4,901,696	0.011009	1,270,891	13,991	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	965,617	21,741,345	0.044414	2,329,080	103,444	54.00
56.00	05600 RADIOISOTOPE	302,933	19,683,093	0.015391	1,423,345	21,907	56.00
57.00	05700 CT SCAN	354,698	43,739,235	0.008109	6,395,780	51,863	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	570,336	12,619,537	0.045195	676,216	30,562	58.00
60.00	06000 LABORATORY	534,193	63,893,749	0.008361	12,085,532	101,047	60.00
65.00	06500 RESPIRATORY THERAPY	202,307	6,267,146	0.032281	3,286,444	106,090	65.00
66.00	06600 PHYSICAL THERAPY	280,442	14,540,561	0.019287	990,698	19,108	66.00
69.00	06900 ELECTROCARDIOLOGY	262,819	14,810,363	0.017746	3,346,310	59,384	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	43,920	12,774,193	0.003438	2,063,470	7,094	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	26,448	9,111,843	0.002903	4,326,554	12,560	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	155,215	27,868,292	0.005570	10,922,786	60,840	73.00
76.97	07697 CARDIAC REHABILITATION	56,577	1,544,947	0.036621	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	7,584	1,831,564	0.004141	12,638	52	90.00
91.00	09100 EMERGENCY	655,469	23,483,856	0.027911	2,890,933	80,689	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	217,275	4,298,986	0.050541	0	0	92.00
200.00	Total (lines 50-199)	6,156,300	329,280,035		62,350,936	993,083	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140011	Period: From 04/01/2012 To 03/31/2013	Worksheet D Part III Date/Time Prepared: 8/19/2013 3:15 pm
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Cost Center Description			Title XVIII					Hospital	PPS
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00	
200.00		Total (lines 30-199)	0	0	0	0	0	200.00	
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School		
			6.00	7.00	8.00	9.00	11.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	17,874	0.00	10,430	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	2,127	0.00	1,263	0	0	31.00	
41.00	04100	SUBPROVIDER - IRF	7,680	0.00	5,581	0	0	41.00	
200.00		Total (lines 30-199)	27,681		17,274	0	0	200.00	
Cost Center Description			PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost					
			12.00	13.00					
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0					30.00
31.00	03100	INTENSIVE CARE UNIT	0	0					31.00
41.00	04100	SUBPROVIDER - IRF	0	0					41.00
200.00		Total (lines 30-199)	0	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet D
Part IV
Date/Time Prepared:
8/19/2013 3:15 pm

Cost Center Description		Title XVIII				Hospital	PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet D
Part IV
Date/Time Prepared:
8/19/2013 3:15 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital			
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	43,495,452	0.000000	0.000000	9,534,935	50.00
51.00	05100	RECOVERY ROOM	0	2,674,177	0.000000	0.000000	795,324	51.00
53.00	05300	ANESTHESIOLOGY	0	4,901,696	0.000000	0.000000	1,270,891	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,741,345	0.000000	0.000000	2,329,080	54.00
56.00	05600	RADIOISOTOPE	0	19,683,093	0.000000	0.000000	1,423,345	56.00
57.00	05700	CT SCAN	0	43,739,235	0.000000	0.000000	6,395,780	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	12,619,537	0.000000	0.000000	676,216	58.00
60.00	06000	LABORATORY	0	63,893,749	0.000000	0.000000	12,085,532	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,267,146	0.000000	0.000000	3,286,444	65.00
66.00	06600	PHYSICAL THERAPY	0	14,540,561	0.000000	0.000000	990,698	66.00
69.00	06900	ELECTROCARDIOLOGY	0	14,810,363	0.000000	0.000000	3,346,310	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,774,193	0.000000	0.000000	2,063,470	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,111,843	0.000000	0.000000	4,326,554	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	27,868,292	0.000000	0.000000	10,922,786	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,544,947	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,831,564	0.000000	0.000000	12,638	90.00
91.00	09100	EMERGENCY	0	23,483,856	0.000000	0.000000	2,890,933	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	4,298,986	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	329,280,035			62,350,936	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet D
Part IV
Date/Time Prepared:
8/19/2013 3:15 pm

Cost Center Description			Title XVIII					Hospital	
			Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 1/1	Outpatient Program Charges on/after 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 1/1	PPS	
			11.00	12.00	12.01	13.00	13.01		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	5,766,984	2,005,574	0	0	50.00	
51.00	05100	RECOVERY ROOM	0	275,667	93,506	0	0	51.00	
53.00	05300	ANESTHESIOLOGY	0	545,077	212,681	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,141,352	1,509,637	0	0	54.00	
56.00	05600	RADIOISOTOPE	0	6,404,556	2,652,770	0	0	56.00	
57.00	05700	CT SCAN	0	9,099,663	3,433,651	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,469,137	856,976	0	0	58.00	
60.00	06000	LABORATORY	0	1,066,948	365,159	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0	475,086	143,729	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	180	0	0	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	0	3,756,620	1,228,014	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	907,119	309,425	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	587,099	254,293	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,123,836	798,107	0	0	73.00	
76.97	07697	CARDIAC REHABILITATION	0	530,212	216,468	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	959,508	247,583	0	0	90.00	
91.00	09100	EMERGENCY	0	3,770,042	1,328,672	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,476,551	466,492	0	0	92.00	
200.00		Total (lines 50-199)	0	44,355,637	16,122,737	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140011	Period: From 04/01/2012 To 03/31/2013	Worksheet D Part IV Date/Time Prepared: 8/19/2013 3:15 pm
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Cost Center Description	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	PPS
	21.00	22.00	23.00	24.00	
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00 05600 RADIOISOTOPE	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00 06000 LABORATORY	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00 Total (Lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140011	Period: From 04/01/2012 To 03/31/2013	Worksheet D Part V Date/Time Prepared: 8/19/2013 3:15 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges					
		PPS Reimbursed Services (see inst.) before 1/1	PPS Reimbursed Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	1.00	2.00	2.01	3.00	4.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.220791	5,766,984	2,005,574	0	0	50.00
51.00	05100 RECOVERY ROOM	0.211292	275,667	93,506	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.066906	545,077	212,681	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.258599	4,141,352	1,509,637	0	0	54.00
56.00	05600 RADIOISOTOPE	0.124407	6,404,556	2,652,770	0	0	56.00
57.00	05700 CT SCAN	0.051188	9,099,663	3,433,651	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.112521	2,469,137	856,976	0	0	58.00
60.00	06000 LABORATORY	0.118534	1,066,948	365,159	1,806	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.382378	475,086	143,729	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.348832	180	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.100011	3,756,620	1,228,014	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.357000	907,119	309,425	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.327234	587,099	254,293	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.295737	2,123,836	798,107	0	103,328	73.00
76.97	07697 CARDIAC REHABILITATION	0.573794	530,212	216,468	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.371825	959,508	247,583	0	0	90.00
91.00	09100 EMERGENCY	0.351856	3,770,042	1,328,672	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.635120	1,476,551	466,492	0	0	92.00
200.00	Subtotal (see instructions)		44,355,637	16,122,737	1,806	103,328	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges				0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		44,355,637	16,122,737	1,806	103,328	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140011	Period: From 04/01/2012 To 03/31/2013	Worksheet D Part V Date/Time Prepared: 8/19/2013 3:15 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs					
	PPS Services (see inst.) before 1/1	PPS Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	5.00	5.01	6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1,273,298	442,813	0	0		50.00
51.00 05100 RECOVERY ROOM	58,246	19,757	0	0		51.00
53.00 05300 ANESTHESIOLOGY	36,469	14,230	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,070,949	390,391	0	0		54.00
56.00 05600 RADIOISOTOPE	796,772	330,023	0	0		56.00
57.00 05700 CT SCAN	465,794	175,762	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	277,830	96,428	0	0		58.00
60.00 06000 LABORATORY	126,470	43,284	214	0		60.00
65.00 06500 RESPIRATORY THERAPY	181,662	54,959	0	0		65.00
66.00 06600 PHYSICAL THERAPY	63	0	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	375,703	122,815	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	323,841	110,465	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	192,119	83,213	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	628,097	236,030	0	30,558		73.00
76.97 07697 CARDIAC REHABILITATION	304,232	124,208	0	0		76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	356,769	92,058	0	0		90.00
91.00 09100 EMERGENCY	1,326,512	467,501	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	937,787	296,278	0	0		92.00
200.00 Subtotal (see instructions)	8,732,613	3,100,215	214	30,558		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0			201.00
202.00 Net Charges (line 200 +/- line 201)	8,732,613	3,100,215	214	30,558		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140011 Component CCN: 14T011		Period: From 04/01/2012 To 03/31/2013		Worksheet D Part II Date/Time Prepared: 8/19/2013 3:15 pm		
				Title XVIII		Subprovider - IRF	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,428,553	43,495,452	0.032844	24,489	804	50.00
51.00	05100	RECOVERY ROOM	37,953	2,674,177	0.014192	871	12	51.00
53.00	05300	ANESTHESIOLOGY	53,961	4,901,696	0.011009	1,239	14	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	965,617	21,741,345	0.044414	142,298	6,320	54.00
56.00	05600	RADIOISOTOPE	302,933	19,683,093	0.015391	11,310	174	56.00
57.00	05700	CT SCAN	354,698	43,739,235	0.008109	129,999	1,054	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	570,336	12,619,537	0.045195	13,934	630	58.00
60.00	06000	LABORATORY	534,193	63,893,749	0.008361	997,404	8,339	60.00
65.00	06500	RESPIRATORY THERAPY	202,307	6,267,146	0.032281	192,646	6,219	65.00
66.00	06600	PHYSICAL THERAPY	280,442	14,540,561	0.019287	4,465,638	86,129	66.00
69.00	06900	ELECTROCARDIOLOGY	262,819	14,810,363	0.017746	24,714	439	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	43,920	12,774,193	0.003438	7,280	25	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26,448	9,111,843	0.002903	12,837	37	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	155,215	27,868,292	0.005570	1,730,537	9,639	73.00
76.97	07697	CARDIAC REHABILITATION	56,577	1,544,947	0.036621	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	7,584	1,831,564	0.004141	0	0	90.00
91.00	09100	EMERGENCY	655,469	23,483,856	0.027911	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	4,298,986	0.000000	0	0	92.00
200.00		Total (lines 50-199)	5,939,025	329,280,035		7,755,196	119,835	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140011 Component CCN: 14T011	Period: From 04/01/2012 To 03/31/2013	Worksheet D Part IV Date/Time Prepared: 8/19/2013 3:15 pm
	Title XVIII	Subprovider - IRF	PPS

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						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140011 Component CCN: 14T011	Period: From 04/01/2012 To 03/31/2013	Worksheet D Part IV Date/Time Prepared: 8/19/2013 3:15 pm
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient Program Charges
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 + col. 7)	Ratio of Cost to Charges (col. 6 + col. 7)	
	6.00	7.00	8.00	9.00	10.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	43,495,452	0.000000	0.000000	24,489 50.00
51.00 05100 RECOVERY ROOM	0	2,674,177	0.000000	0.000000	871 51.00
53.00 05300 ANESTHESIOLOGY	0	4,901,696	0.000000	0.000000	1,239 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	21,741,345	0.000000	0.000000	142,298 54.00
56.00 05600 RADIOISOTOPE	0	19,683,093	0.000000	0.000000	11,310 56.00
57.00 05700 CT SCAN	0	43,739,235	0.000000	0.000000	129,999 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	12,619,537	0.000000	0.000000	13,934 58.00
60.00 06000 LABORATORY	0	63,893,749	0.000000	0.000000	997,404 60.00
65.00 06500 RESPIRATORY THERAPY	0	6,267,146	0.000000	0.000000	192,646 65.00
66.00 06600 PHYSICAL THERAPY	0	14,540,561	0.000000	0.000000	4,465,638 66.00
69.00 06900 ELECTROCARDIOLOGY	0	14,810,363	0.000000	0.000000	24,714 69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,774,193	0.000000	0.000000	7,280 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	9,111,843	0.000000	0.000000	12,837 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	27,868,292	0.000000	0.000000	1,730,537 73.00
76.97 07697 CARDIAC REHABILITATION	0	1,544,947	0.000000	0.000000	0 76.97
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0	1,831,564	0.000000	0.000000	0 90.00
91.00 09100 EMERGENCY	0	23,483,856	0.000000	0.000000	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	4,298,986	0.000000	0.000000	0 92.00
200.00 Total (lines 50-199)	0	329,280,035			7,755,196 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140011 Component CCN: 14T011	Period: From 04/01/2012 To 03/31/2013	Worksheet D Part IV Date/Time Prepared: 8/19/2013 3:15 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description			Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 1/1	Outpatient Program Charges on/after 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 1/1	
			11.00	12.00	12.01	13.00	13.01	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140011 Component CCN: 14T011	Period: From 04/01/2012 To 03/31/2013	Worksheet D Part IV Date/Time Prepared: 8/19/2013 3:15 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
		21.00	22.00	23.00	24.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140011	Period: From 04/01/2012 To 03/31/2013	Worksheet D-1 Date/Time Prepared: 8/19/2013 3:15 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		17,874	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		17,874	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)		14,900	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		10,430	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)		16,409,816	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)		16,409,816	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		10,661,416	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		10,661,416	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.539178	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)		715.53	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)		16,409,816	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)		918.08	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		9,575,574	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)		9,575,574	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140011	Period: From 04/01/2012 To 03/31/2013	Worksheet D-1 Date/Time Prepared: 8/19/2013 3:15 pm	
Cost Center Description			Title XVIII		Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	3,951,291	2,127	1,857.68	1,263	2,346,250	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)				13,331,966	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				25,253,790	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)				887,962	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				993,083	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				1,881,045	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				23,372,745	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)				2,974	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				918.08	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				2,730,370	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140011		Period: From 04/01/2012 To 03/31/2013		Worksheet D-1 Date/Time Prepared: 8/19/2013 3:15 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,305,837	16,409,816	0.079577	2,730,370	217,275	90.00
91.00	Nursing School cost	0	16,409,816	0.000000	2,730,370	0	91.00
92.00	Allied health cost	0	16,409,816	0.000000	2,730,370	0	92.00
93.00	All other Medical Education	0	16,409,816	0.000000	2,730,370	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140011 Component CCN: 14T011	Period: From 04/01/2012 To 03/31/2013	Worksheet D-1 Date/Time Prepared: 8/19/2013 3:15 pm
		Title XVIII	Subprovider - IRF	PPS
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)		7,680	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,680	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)		7,680	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)		5,581	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)		7,576,269	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)		7,576,269	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		12,819,899	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		12,819,899	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.590977	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)		1,669.26	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)		7,576,269	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)		986.49	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,505,601	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)		5,505,601	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140011 Component CCN: 14T011		Period: From 04/01/2012 To 03/31/2013		Worksheet D-1 Date/Time Prepared: 8/19/2013 3:15 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)					2,323,508	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					7,829,109	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)					451,615	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					119,835	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					571,450	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					7,257,659	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: 140011 Component CCN: 14T011		Period: From 04/01/2012 To 03/31/2013		Worksheet D-1 Date/Time Prepared: 8/19/2013 3:15 pm	
		Title XVIII		Subprovider - IRF		PPS	
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	621,454	7,576,269	0.082026	0	0	90.00
91.00	Nursing School cost	0	7,576,269	0.000000	0	0	91.00
92.00	Allied health cost	0	7,576,269	0.000000	0	0	92.00
93.00	All other Medical Education	0	7,576,269	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140011	Period: From 04/01/2012 To 03/31/2013	Worksheet D-3 Date/Time Prepared: 8/19/2013 3:15 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		8,833,990	30.00
31.00	03100	INTENSIVE CARE UNIT		1,727,784	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.221503	9,534,935	50.00
51.00	05100	RECOVERY ROOM	0.211292	795,324	51.00
53.00	05300	ANESTHESIOLOGY	0.066906	1,270,891	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.258599	2,329,080	54.00
56.00	05600	RADIOISOTOPE	0.124407	1,423,345	56.00
57.00	05700	CT SCAN	0.051188	6,395,780	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.112521	676,216	58.00
60.00	06000	LABORATORY	0.119038	12,085,532	60.00
65.00	06500	RESPIRATORY THERAPY	0.383332	3,286,444	65.00
66.00	06600	PHYSICAL THERAPY	0.348832	990,698	66.00
69.00	06900	ELECTROCARDIOLOGY	0.100070	3,346,310	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.357000	2,063,470	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.327234	4,326,554	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.295737	10,922,786	73.00
76.97	07697	CARDIAC REHABILITATION	0.574706	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.371825	12,638	90.00
91.00	09100	EMERGENCY	0.352035	2,890,933	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.635120	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		62,350,936	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)		62,350,936	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140011 Component CCN: 14T011	Period: From 04/01/2012 To 03/31/2013	Worksheet D-3 Date/Time Prepared: 8/19/2013 3:15 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
41.00	04100 SUBPROVIDER - IRF		9,294,895	41.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.221503	24,489	5,424 50.00
51.00	05100 RECOVERY ROOM	0.211292	871	184 51.00
53.00	05300 ANESTHESIOLOGY	0.066906	1,239	83 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.258599	142,298	36,798 54.00
56.00	05600 RADIOISOTOPE	0.124407	11,310	1,407 56.00
57.00	05700 CT SCAN	0.051188	129,999	6,654 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.112521	13,934	1,568 58.00
60.00	06000 LABORATORY	0.119038	997,404	118,729 60.00
65.00	06500 RESPIRATORY THERAPY	0.383332	192,646	73,847 65.00
66.00	06600 PHYSICAL THERAPY	0.348832	4,465,638	1,557,757 66.00
69.00	06900 ELECTROCARDIOLOGY	0.100070	24,714	2,473 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.357000	7,280	2,599 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.327234	12,837	4,201 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.295737	1,730,537	511,784 73.00
76.97	07697 CARDIAC REHABILITATION	0.574706	0	0 76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.371825	0	0 90.00
91.00	09100 EMERGENCY	0.352035	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.635120	0	0 92.00
200.00	Total (sum of lines 50-94 and 96-98)		7,755,196	2,323,508 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net Charges (line 200 minus line 201)		7,755,196	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140011	Period: From 04/01/2012 To 03/31/2013	Worksheet E Part A Date/Time Prepared: 8/19/2013 3:15 pm
		Title XVIII	Hospital	PPS
		before 1/1	on/after 1/1	
		1.00	1.01	
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments	19,144,142		1.00
2.00	Outlier payments for discharges. (see instructions)	235,805		2.00
2.01	Outlier reconciliation amount	0		2.01
3.00	Managed Care Simulated Payments	0		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	76.85		4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)	0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.	0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)	0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00		11.00
12.00	Current year allowable FTE (see instructions)	0.00		12.00
13.00	Total allowable FTE count for the prior year.	0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00		15.00
16.00	Adjustment for residents in initial years of the program	0.00		16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00		17.00
18.00	Adjusted rolling average FTE count	0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000		21.00
22.00	IME payment adjustment (see instructions)	0		22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000		26.00
27.00	IME payments adjustment. (see instructions)	0.000000		27.00
28.00	IME Adjustment (see instructions)	0		28.00
29.00	Total IME payment (sum of lines 22 and 28)	0		29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	5.82		30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)	10.85		31.00
32.00	Sum of lines 30 and 31	16.67		32.00
33.00	Allowable disproportionate share percentage (see instructions)	3.59		33.00
34.00	Disproportionate share adjustment (see instructions)	687,275		34.00
Additional payment for high percentage of ESRD beneficiary discharges				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0	0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)	0		46.00
47.00	Subtotal (see instructions)	20,067,222		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	23,461,747		48.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140011	Period: From 04/01/2012 To 03/31/2013	Worksheet E Part A Date/Time Prepared: 8/19/2013 3:15 pm
		Title XVIII	Hospital	PPS
			before 1/1	on/after 1/1
			1.00	1.01
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		22,613,116	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		1,532,017	50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0	56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).		0	57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		24,145,133	59.00
60.00	Primary payer payments		344	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		24,144,789	61.00
62.00	Deductibles billed to program beneficiaries		2,282,064	62.00
63.00	Coinsurance billed to program beneficiaries		74,194	63.00
64.00	Allowable bad debts (see instructions)		664,570	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		465,199	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		533,425	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		22,253,730	67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0	68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.93	HVBP incentive payment (see instructions)		22,935	70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		-41,594	70.94
70.95	Recovery of Accelerated Depreciation		0	70.95
70.96	Low Volume Payment-1		0	70.96
70.97	Low Volume Payment-2		0	70.97
70.98	Low Volume Payment-3		0	70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		22,235,071	71.00
72.00	Interim payments		20,608,155	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)		1,626,916	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	75.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0	90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the Time Value of Money		0.00	94.00
95.00	Time Value of Money for operating expenses(see instructions)		0	95.00
96.00	Time Value of Money for capital related expenses (see instructions)		0	96.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140011		Period: From 04/01/2012 To 03/31/2013		Worksheet DSH	
		Title XVIII		Hospital		PPS	
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	5.82	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	10.85	0.00			10.85	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	16.67	0.00			10.85	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	MDH				MDH	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	76.85	0.00			76.85	5.00
6.00	Disproportionate Share Payment Percentage (transfer to Worksheet E, Part A, line 33)	3.59	0.00			0.00	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				No	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No				No	9.00
10.00	S-2, Line 45	No				No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	Yes				Yes	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	1.59	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	1,366	0			1,366	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	330	0			330	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	5	0			5	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	146	0			146	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	1,847	0			1,847	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	17,027	0			17,027	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	17,027	0			17,027	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	10.85	0.00			10.85	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140011		Period: From 04/01/2012 To 03/31/2013		Worksheet DSH Date/Time Prepared: 8/19/2013 3:15 pm	
		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	False	0.00		0.00	False	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	True	3.59		0.00	True	29.00
30.00	Line 28 or 29 as applicable		3.59		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		0.00		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE							
32.00	Does the hospital qualify under the Pickle amendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	True				True	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Rural				Rural	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140011	Period: From 04/01/2012 To 03/31/2013	Worksheet DSH Date/Time Prepared: 8/19/2013 3:15 pm
		Title XVIII	Hospital	PPS

		Revised		
		Percentage		
		6.00		
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE				
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	0.00		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	5.20		29.00
30.00	Line 28 or 29 as applicable	5.20		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	0.00		31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140011	Period: From 04/01/2012 To 03/31/2013	Worksheet E Part B Date/Time Prepared: 8/19/2013 3:15 pm
		Title XVIII	Hospital	PPS
			before 1/1	on/after 1/1
			1.00	1.01
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		30,772	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		8,732,613	2.00
3.00	PPS payments		6,463,221	3.00
4.00	Outlier payment (see instructions)		70,404	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.804	5.00
6.00	Line 2 times line 5		7,021,021	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		93.06	7.00
8.00	Transitional corridor payment (see instructions)		414,287	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)		30,772	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		105,134	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)		105,134	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)		105,134	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		74,362	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)		30,772	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		9,242,230	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,190,558	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)		7,082,444	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)		7,082,444	30.00
31.00	Primary payer payments		236	31.00
32.00	Subtotal (line 30 minus line 31)		7,082,208	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)		522,961	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		366,073	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		445,952	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		7,448,281	37.00
38.00	MSP-LCC reconciliation amount from PS&R		47	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	AB Re-billing demo amount (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		7,448,234	40.00
41.00	Interim payments		8,491,382	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		-1,043,148	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00
				Overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0
				112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet E-1
Part I
Date/Time Prepared:
8/19/2013 3:15 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		20,321,337		8,465,481	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		03/11/2013	1,295,694	09/18/2012	25,901	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		09/18/2012	1,008,876		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)		286,818		25,901	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)		20,608,155		8,491,382	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		1,626,916		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		1,043,148	6.02	
7.00	Total Medicare program liability (see instructions)		22,235,071		7,448,234	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140011
Component CCN: 14T011

Period:
From 04/01/2012
To 03/31/2013

Worksheet E-1
Part I
Date/Time Prepared:
8/19/2013 3:15 pm

Title XVIII

Subprovider -
IRF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					0 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		8,174,286			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)					0 3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0			0 3.01
3.02		09/14/2012	1,494			0 3.02
3.03		03/11/2013	17,618			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)		19,112			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)		8,193,398			0 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)					0 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)					0 6.00
6.01	SETTLEMENT TO PROVIDER		0			0 6.01
6.02	SETTLEMENT TO PROGRAM		45,505			0 6.02
7.00	Total Medicare program liability (see instructions)		8,147,893			0 7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					0 8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140011 Component CCN: 14T011	Period: From 04/01/2012 To 03/31/2013	Worksheet E-3 Part III Date/Time Prepared: 8/19/2013 3:15 pm
		Title XVIIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			7,622,631 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0159 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			357,440 3.00
4.00	Outlier Payments			247,354 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			21.041096 10.00
11.00	Medical Education Adjustment Factor {((1 + (line 9/line 10)) raised to the power of .6876 -1}.			0.000000 11.00
12.00	Medical Education Adjustment (line 1 multiplied by line 11).			0 12.00
13.00	Total PPS Payment (sum of lines 1, 3, 4 and 12)			8,227,425 13.00
14.00	Nursing and Allied Health Managed Care payment (see instruction)			0 14.00
15.00	Organ acquisition			0 15.00
16.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 16.00
17.00	Subtotal (see instructions)			8,227,425 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			8,227,425 19.00
20.00	Deductibles			75,462 20.00
21.00	Subtotal (line 19 minus line 20)			8,151,963 21.00
22.00	Coinsurance			14,886 22.00
23.00	Subtotal (line 21 minus line 22)			8,137,077 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			15,452 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			10,816 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			9,818 26.00
27.00	Subtotal (sum of lines 23 and 25)			8,147,893 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			8,147,893 32.00
33.00	Interim payments			8,193,398 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus the sum lines 33 and 34)			-45,505 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4			247,354 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

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

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet G

Date/Time Prepared:
8/19/2013 3:15 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	616,690	0	0	0	1.00
2.00	Temporary investments	4,106	0	0	0	2.00
3.00	Notes receivable	267,447	0	0	0	3.00
4.00	Accounts receivable	87,925,864	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-66,296,962	0	0	0	6.00
7.00	Inventory	1,541,642	0	0	0	7.00
8.00	Prepaid expenses	653,380	0	0	0	8.00
9.00	Other current assets	438,133	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)	25,150,300	0	0	0	11.00
FIXED ASSETS						
12.00	Land	3,696,434	0	0	0	12.00
13.00	Land improvements	4,238,100	0	0	0	13.00
14.00	Accumulated depreciation	-1,963,891	0	0	0	14.00
15.00	Buildings	65,740,868	0	0	0	15.00
16.00	Accumulated depreciation	-29,062,878	0	0	0	16.00
17.00	Leasehold improvements	4,220	0	0	0	17.00
18.00	Accumulated depreciation	-727	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	162,746	0	0	0	21.00
22.00	Accumulated depreciation	-125,118	0	0	0	22.00
23.00	Major movable equipment	24,816,434	0	0	0	23.00
24.00	Accumulated depreciation	-14,975,634	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	151,340	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	52,681,894	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	80,896,609	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,096,141	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	82,992,750	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	160,824,944	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,859,499	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	5,028,464	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,519,243	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	1,899,271	0	0	0	43.00
44.00	Other current liabilities	1,240,813	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	12,547,290	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	47,536,094	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,434,950	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	48,971,044	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	61,518,334	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	99,306,610				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)	99,306,610	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	160,824,944	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet G-1

Date/Time Prepared:
8/19/2013 3:15 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		87,103,073		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		12,203,540			2.00
3.00	Total (sum of line 1 and line 2)		99,306,613		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		99,306,613		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00	ROUNDING	3		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		3		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		99,306,610		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00	ROUNDING		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: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet G-2
Parts I & II
Date/Time Prepared:
8/19/2013 3:15 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	17,600,348		17,600,348	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	14,352,700		14,352,700	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)	31,953,048		31,953,048	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	2,750,172		2,750,172	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)	2,750,172		2,750,172	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	34,703,220		34,703,220	17.00
18.00	Ancillary services	111,296,810	218,643,782	329,940,592	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	146,000,030	218,643,782	364,643,812	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		91,208,467		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)		91,208,467		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140011

Period:
From 04/01/2012
To 03/31/2013

Worksheet G-3

Date/Time Prepared:
8/19/2013 3:15 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	364,643,812	1.00
2.00	Less contractual allowances and discounts on patients' accounts	250,174,497	2.00
3.00	Net patient revenues (line 1 minus line 2)	114,469,315	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	91,208,467	4.00
5.00	Net income from service to patients (line 3 minus line 4)	23,260,848	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	539,929	6.00
7.00	Income from investments	6,796,329	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	10,740	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	330,253	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	2,510	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	47,680	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	216,278	22.00
23.00	Governmental appropriations	218,758	23.00
24.00	MISCELLANEOUS INCOME	10,912	24.00
25.00	Total other income (sum of lines 6-24)	8,173,389	25.00
26.00	Total (line 5 plus line 25)	31,434,237	26.00
27.00	CORP ALLOCATION AND LOSS ON EQUIPMEN	19,230,697	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	19,230,697	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	12,203,540	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140011	Period: From 04/01/2012 To 03/31/2013	Worksheet L Parts I-III Date/Time Prepared: 8/19/2013 3:15 pm
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,511,612	1.00
2.00	Capital DRG outlier payments		20,405	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		46.65	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		1,532,017	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00