

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: 140184	Period: From 05/01/2012 To 04/30/2013	Worksheet S Parts I-III Date/Time Prepared: 9/30/2013 8:52 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: _____ Time: _____
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 MARION MEMORIAL HOSPITAL (140184) for the cost reporting period beginning 05/01/2012 and ending 04/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-138,047	-269,454	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
200.00 Total	0	-138,047	-269,454	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: 140184			Period: From 05/01/2012 To 04/30/2013		Worksheet S-2 Part I Date/Time Prepared: 9/30/2013 8:52 am			
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 917 WEST MAIN ST			PO Box:				1.00		
2.00	City: MARION			State: IL		Zip Code: 62959		County: WILLIAMSON		
		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		MARION MEMORIAL HOSPITAL	140184	99914	1	07/01/1996	N	P	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		MARION MEMORIAL HOSPITAL	14U184	99914		03/23/1999	N	P	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC									
16.00	Hospital-Based Health Clinic - FOHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						05/01/2012		04/30/2013	
21.00	Type of Control (see instructions)						4			
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	
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	
		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.		4,853	0	3	0	8	146		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.		0	0	0	0	0	0		
							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			
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			
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			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140184	Period: From 05/01/2012 To 04/30/2013	Worksheet S-2 Part I Date/Time Prepared: 9/30/2013 8:52 am		
		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.	05/01/2012	04/30/2013			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	Y	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		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet S-2
Part I
Date/Time Prepared:
9/30/2013 8:52 am

		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 report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 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.	N				75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			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.	N	N	N	N	109.00
				1.00	2.00	3.00
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	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:	121,963	1,148,517		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	449008	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: CHS/COMMUNITY HEALTH SYSTEMS, INC.	Contractor's Name: WISCONSIN PHYSICIAN SERVICES		Contractor's Number: 52280	
142.00	Street: 4000 MERIDIAN BLVD.	PO Box:			
143.00	City: FRANKLIN	State: TN		Zip Code: 37067	
				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: 140184	Period: From 05/01/2012 To 04/30/2013	Worksheet S-2 Part II Date/Time Prepared: 9/30/2013 8:52 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	07/26/2013	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140184	Period: From 05/01/2012 To 04/30/2013	Worksheet S-2 Part II Date/Time Prepared: 9/30/2013 8:52 am	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
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			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			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.			Y	12/31/2012
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.	RACHAEL	DEEN		41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-2780	RACHAEL_DEEN@CHS.NET		43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	07/26/2013	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
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.	REVENUE MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

VOLUNTARY CONTACT INFORMATION

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet S-2
Part V
Date/Time Prepared:
9/30/2013 8:52 am

		1.00	
Cost Report Preparer Contact Information			
1.00	First Name	RACHAEL	1.00
2.00	Last Name	DEEN	2.00
3.00	Title	REVENUE MANAGER	3.00
4.00	Employer	COMMUNITY HEALTH SYSTEMS, INC	4.00
5.00	Phone Number	(615)465-278	5.00
6.00	E-mail Address	RACHAEL_DEEN@CHS.NET	6.00
7.00	Department	REVENUE MANAGEMENT	7.00
8.00	Mailing Address 1	4000 MERIDIAN BLVD.	8.00
9.00	Mailing Address 2		9.00
10.00	City	FRANKLIN	10.00
11.00	State	TN	11.00
12.00	Zip	37067	12.00
Officer or Administrator of Provider Contact Information			
13.00	First Name	LOREN	13.00
14.00	Last Name	RIALS	14.00
15.00	Title	CFO	15.00
16.00	Employer	HEARTLAND REGIONAL MEDICAL CENTER	16.00
17.00	Phone Number	(618)998-7449	17.00
18.00	E-mail Address	LOREN_RIALS@CHS.NET	18.00
19.00	Department	ACCOUNTING	19.00
20.00	Mailing Address 1	3333 WEST DEYOUNG	20.00
21.00	Mailing Address 2		21.00
22.00	City	MARION	22.00
23.00	State	IL	23.00
24.00	Zip	62959	24.00

HFS Supplemental Information		Provider CCN: 140184	Period: From 05/01/2012 To 04/30/2013	Worksheet S-2 Part IX Date/Time Prepared: 9/30/2013 8:52 am	
			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: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet S-3
Part I
Date/Time Prepared:
9/30/2013 8:52 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Visi ts / Tri ps	
					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	80	29,200	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)		80	29,200	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,380	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	43.00				0	13.00
14.00 Total (see instructions)		92	33,580	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	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	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		92				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: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet S-3
Part I
Date/Time Prepared:
9/30/2013 8:52 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	7,474	2,898	13,824			1.00
2.00 HMO	340	637				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	7,474	2,898	13,824			7.00
8.00 INTENSIVE CARE UNIT	1,847	307	3,050			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		1,168	1,628			13.00
14.00 Total (see instructions)	9,321	4,373	18,502	0.00	457.16	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0	0	0	0.00	0.00	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	0	0	0	0.00	0.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	457.16	27.00
28.00 Observation Bed Days		0	2,025			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: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet S-3
Part I
Date/Time Prepared:
9/30/2013 8:52 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)		0	1,992	1,194	4,868	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	1,992	1,194	4,868	14.00	
15.00 CAH visits						15.00	
16.00 SUBPROVIDER - IPF						16.00	
17.00 SUBPROVIDER - IRF						17.00	
18.00 SUBPROVIDER						18.00	
19.00 SKILLED NURSING FACILITY	0.00					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	0.00					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: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet S-3
Part II
Date/Time Prepared:
9/30/2013 8:52 am

	Worksheet A Line Number	Amount Reported	Recl assi fi 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	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	23,785,425	0	23,785,425	950,896.00	25.01
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		0	0	0	0.00	0.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		109,920	21,933	131,853	2,024.00	65.14
OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		754,141	0	754,141	20,542.00	36.71
12.00	Contract management and administrative services		175,816	0	175,816	2,353.00	74.72
13.00	Contract Labor: Physician-Part A - Administrative		52,893	0	52,893	2,833.00	18.67
14.00	Home office salaries & wage-related costs		1,954,673	0	1,954,673	35,991.00	54.31
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		5,953,413	0	5,953,413		
18.00	Wage-related costs (other) Wkst S-3, Part IV line 25		0	0	0		
19.00	Excluded areas		16,220	0	16,220		
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		0	0	0		
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	174,702	0	174,702	5,490.00	31.82
27.00	Administrative & General	5.00	2,935,723	497,498	3,433,221	124,854.00	27.50
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	335,815	0	335,815	13,641.00	24.62
31.00	Laundry & Linen Service	8.00	38,663	0	38,663	2,989.00	12.94
32.00	Housekeeping	9.00	878,109	0	878,109	74,541.00	11.78
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	741,044	-263,552	477,492	36,912.89	12.94
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	263,552	263,552	20,374.11	12.94
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	1,417,842	-754,282	663,560	13,509.00	49.12
39.00	Central Services and Supply	14.00	139,822	0	139,822	11,722.00	11.93
40.00	Pharmacy	15.00	1,134,499	0	1,134,499	27,479.00	41.29
41.00	Medical Records & Medical Records Library	16.00	452,248	0	452,248	28,236.00	16.02

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet S-3
Part II
Date/Time Prepared:
9/30/2013 8:52 am

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

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet S-3
Part III
Date/Time Prepared:
9/30/2013 8:52 am

	Worksheet A Line Number	Amount Reported	Recl assi fi 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	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	23,785,425	0	23,785,425	950,896.00	25.01	1.00
2.00	Excluded area salaries (see instructions)	109,920	21,933	131,853	2,024.00	65.14	2.00
3.00	Subtotal salaries (line 1 minus line 2)	23,675,505	-21,933	23,653,572	948,872.00	24.93	3.00
4.00	Subtotal other wages & related costs (see inst.)	2,937,523	0	2,937,523	61,719.00	47.60	4.00
5.00	Subtotal wage-related costs (see inst.)	5,953,413	0	5,953,413	0.00	25.17	5.00
6.00	Total (sum of lines 3 thru 5)	32,566,441	-21,933	32,544,508	1,010,591.00	32.20	6.00
7.00	Total overhead cost (see instructions)	8,248,467	-256,784	7,991,683	359,748.00	22.21	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 140184	Period: From 05/01/2012 To 04/30/2013	Worksheet S-3 Part IV Date/Time Prepared: 9/30/2013 8:52 am
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	448,503	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration Fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	2,710,948	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	69,153	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	23,747	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)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	684,332	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	1,708,998	17.00
18.00	Medicare Taxes - Employers Portion Only	254,431	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	10,279	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	59,242	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,969,633	24.00
Part B - Other than Core Related Cost			
25.00	EARNED INCOME CR, OTHER PR TAX, BEN.	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet S-3
Part V
Date/Time Prepared:
9/30/2013 8:52 am

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	982,850	0	1.00
2.00	Hospital	982,850	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet S-7

Date/Time Prepared:
9/30/2013 8:52 am

		1.00	2.00		
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.				1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.				2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	0 3.00
4.00		RUL	0	0	0 4.00
5.00		RVX	0	0	0 5.00
6.00		RVL	0	0	0 6.00
7.00		RHX	0	0	0 7.00
8.00		RHL	0	0	0 8.00
9.00		RMX	0	0	0 9.00
10.00		RML	0	0	0 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	0	0	0 12.00
13.00		RUB	0	0	0 13.00
14.00		RUA	0	0	0 14.00
15.00		RVC	0	0	0 15.00
16.00		RVB	0	0	0 16.00
17.00		RVA	0	0	0 17.00
18.00		RHC	0	0	0 18.00
19.00		RHB	0	0	0 19.00
20.00		RHA	0	0	0 20.00
21.00		RMC	0	0	0 21.00
22.00		RMB	0	0	0 22.00
23.00		RMA	0	0	0 23.00
24.00		RLB	0	0	0 24.00
25.00		RLA	0	0	0 25.00
26.00		ES3	0	0	0 26.00
27.00		ES2	0	0	0 27.00
28.00		ES1	0	0	0 28.00
29.00		HE2	0	0	0 29.00
30.00		HE1	0	0	0 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	0	0	0 32.00
33.00		HC2	0	0	0 33.00
34.00		HC1	0	0	0 34.00
35.00		HB2	0	0	0 35.00
36.00		HB1	0	0	0 36.00
37.00		LE2	0	0	0 37.00
38.00		LE1	0	0	0 38.00
39.00		LD2	0	0	0 39.00
40.00		LD1	0	0	0 40.00
41.00		LC2	0	0	0 41.00
42.00		LC1	0	0	0 42.00
43.00		LB2	0	0	0 43.00
44.00		LB1	0	0	0 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	0	0	0 46.00
47.00		CD2	0	0	0 47.00
48.00		CD1	0	0	0 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	0	0	0 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	0	0	0 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	0	0	0 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	0	0	0 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet S-7

Date/Time Prepared:
9/30/2013 8:52 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	0	0	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
SNF SERVICES						
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).					201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		0	0.00		202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		0			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140184	Period: From 05/01/2012 To 04/30/2013	Worksheet S-10 Date/Time Prepared: 9/30/2013 8:52 am
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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)		0.134764	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		10,035,796	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		3,462,022	5.00	
6.00	Medicaid charges		90,827,178	6.00	
7.00	Medicaid cost (line 1 times line 6)		12,240,234	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		2,651	9.00	
10.00	Stand-alone SCHIP charges		52,287	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		7,046	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		4,395	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		20,697	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		4,395	19.00	
			Uninsured patients	Insured patients	
			1.00	2.00	
			Total (col. 1 + col. 2)		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	4,252,693	477,412	4,730,105	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	573,110	64,338	637,448	21.00
22.00	Partial payment by patients approved for charity care	275	3,261	3,536	22.00
23.00	Cost of charity care (line 21 minus line 22)	572,835	61,077	633,912	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)		8,519,639	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		427,125	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		8,092,514	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		1,090,580	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		1,724,492	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,728,887	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet A
Date/Time Prepared:
9/30/2013 8:52 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,012,006	1,012,006	398,222	1,410,228	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,916,635	2,916,635	2,311,363	5,227,998	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	174,702	217,509	392,211	3,977,740	4,369,951	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,935,723	20,295,761	23,231,484	-5,265,530	17,965,954	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	335,815	1,852,498	2,188,313	0	2,188,313	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	38,663	267,869	306,532	0	306,532	8.00
9.00	00900	HOUSEKEEPING	878,109	208,346	1,086,455	0	1,086,455	9.00
10.00	01000	DIETARY	741,044	799,361	1,540,405	-548,488	991,917	10.00
11.00	01100	CAFETERIA	0	0	0	547,844	547,844	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,417,842	345,919	1,763,761	-983,909	779,852	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	139,822	4,442,027	4,581,849	-4,167,500	414,349	14.00
15.00	01500	PHARMACY	1,134,499	4,087,075	5,221,574	-3,987,655	1,233,919	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	452,248	484,468	936,716	0	936,716	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,320,653	2,149,026	6,469,679	-422,192	6,047,487	30.00
31.00	03100	INTENSIVE CARE UNIT	2,032,235	379,600	2,411,835	-1,251	2,410,584	31.00
43.00	04300	NURSERY	325,509	111,483	436,992	181,220	618,212	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,323,167	2,916,563	4,239,730	69,948	4,309,678	50.00
51.00	05100	RECOVERY ROOM	302,349	52,454	354,803	-354,803	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	670,232	107,925	778,157	236,877	1,015,034	52.00
53.00	05300	ANESTHESIOLOGY	0	4,492,297	4,492,297	-14,909	4,477,388	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,419,848	1,789,658	3,209,506	-150,513	3,058,993	54.00
54.01	05401	ULTRASOUND	161,310	77,921	239,231	-56,385	182,846	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	147,727	287,014	434,741	0	434,741	56.00
57.00	05700	CT SCAN	299,681	266,360	566,041	-195,195	370,846	57.00
58.00	05800	MRI	56,166	128,816	184,982	-63,790	121,192	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,044,201	2,474,943	3,519,144	-1,066,733	2,452,411	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	992,823	992,823	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	456,025	238,954	694,979	-123,177	571,802	65.00
66.00	06600	PHYSICAL THERAPY	448,157	96,218	544,375	-6,497	537,878	66.00
67.00	06700	OCCUPATIONAL THERAPY	63,425	5,023	68,448	0	68,448	67.00
68.00	06800	SPEECH PATHOLOGY	69,813	5,478	75,291	0	75,291	68.00
69.00	06900	ELECTROCARDIOLOGY	776,295	1,558,939	2,335,234	-180,569	2,154,665	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,838,240	1,838,240	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,572,779	2,572,779	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,840,539	3,840,539	73.00
74.00	07400	RENAL DIALYSIS	0	393,542	393,542	0	393,542	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03021	SLEEP LAB	0	219,203	219,203	0	219,203	76.01
76.03	03023	WOUND CARE	58,526	42,377	100,903	-3,861	97,042	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,451,719	1,983,180	3,434,899	291,622	3,726,521	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	61,948	56,771	118,719	-118,719	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	0	614	614	-614	0	96.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,737,453	56,763,833	80,501,286	-453,073	80,048,213	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,053	7,053	0	7,053	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	OTHER NON-REIMBURSABLE SENIOR CIRCLE	47,972	12,114	60,086	0	60,086	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	OTHER NONREIMBURSABLE MARKETING	0	0	0	453,073	453,073	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	23,785,425	56,783,000	80,568,425	0	80,568,425	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet A
Date/Time Prepared:
9/30/2013 8:52 am

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	671,309	2,081,537	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	283,302	5,511,300	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	-1,602	4,368,349	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-7,489,494	10,476,460	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-5,209	2,183,104	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	306,532	8.00
9.00	00900	HOUSEKEEPING	0	1,086,455	9.00
10.00	01000	DIETARY	0	991,917	10.00
11.00	01100	CAFETERIA	-443,134	104,710	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	-245	779,607	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	414,349	14.00
15.00	01500	PHARMACY	0	1,233,919	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,120	932,596	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-927,090	5,120,397	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,410,584	31.00
43.00	04300	NURSERY	0	618,212	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-916,950	3,392,728	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,015,034	52.00
53.00	05300	ANESTHESIOLOGY	-4,290,072	187,316	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-694,688	2,364,305	54.00
54.01	05401	ULTRASOUND	0	182,846	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	434,741	56.00
57.00	05700	CT SCAN	0	370,846	57.00
58.00	05800	MRI	0	121,192	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-1,080	2,451,331	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	992,823	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	571,802	65.00
66.00	06600	PHYSICAL THERAPY	0	537,878	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	68,448	67.00
68.00	06800	SPEECH PATHOLOGY	0	75,291	68.00
69.00	06900	ELECTROCARDIOLOGY	-503,338	1,651,327	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,838,240	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,572,779	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-3,597	3,836,942	73.00
74.00	07400	RENAL DIALYSIS	0	393,542	74.00
76.00	03020	ACUPUNCTURE	0	0	76.00
76.01	03021	SLEEP LAB	-208,656	10,547	76.01
76.03	03023	WOUND CARE	0	97,042	76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-1,457,484	2,269,037	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	0	0	96.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-15,992,148	64,056,065	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,053	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	OTHER NON-REIMBURSABLE SENIOR CIRCLE	0	60,086	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	194.00
194.01	07953	OTHER NONREIMBURSABLE MARKETING	0	453,073	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	-15,992,148	64,576,277	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet Non-CMS W
Date/Time Prepared:
9/30/2013 8:52 am

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
3.00 OTHER CAP REL COSTS	00300		3.00
4.00 EMPLOYEE BENEFITS	00400		4.00
5.00 ADMINISTRATIVE & GENERAL	00500		5.00
6.00 MAINTENANCE & REPAIRS	00600		6.00
7.00 OPERATION OF PLANT	00700		7.00
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
12.00 MAINTENANCE OF PERSONNEL	01200		12.00
13.00 NURSING ADMINISTRATION	01300		13.00
14.00 CENTRAL SERVICES & SUPPLY	01400		14.00
15.00 PHARMACY	01500		15.00
16.00 MEDICAL RECORDS & LIBRARY	01600		16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS	03000		30.00
31.00 INTENSIVE CARE UNIT	03100		31.00
43.00 NURSERY	04300		43.00
44.00 SKILLED NURSING FACILITY	04400		44.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	05000		50.00
51.00 RECOVERY ROOM	05100		51.00
52.00 DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00 ANESTHESIOLOGY	05300		53.00
54.00 RADIOLOGY-DIAGNOSTIC	05400		54.00
54.01 ULTRASOUND	05401		54.01
55.00 RADIOLOGY-THERAPEUTIC	05500		55.00
56.00 RADIOISOTOPE	05600		56.00
57.00 CT SCAN	05700		57.00
58.00 MRI	05800		58.00
59.00 CARDIAC CATHETERIZATION	05900		59.00
60.00 LABORATORY	06000		60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELL	06200		62.00
64.00 INTRAVENOUS THERAPY	06400		64.00
65.00 RESPIRATORY THERAPY	06500		65.00
66.00 PHYSICAL THERAPY	06600		66.00
67.00 OCCUPATIONAL THERAPY	06700		67.00
68.00 SPEECH PATHOLOGY	06800		68.00
69.00 ELECTROCARDIOLOGY	06900		69.00
70.00 ELECTROENCEPHALOGRAPHY	07000		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00 DRUGS CHARGED TO PATIENTS	07300		73.00
74.00 RENAL DIALYSIS	07400		74.00
76.00 ACUPUNCTURE	03020		76.00
76.01 SLEEP LAB	03021		76.01
76.03 WOUND CARE	03023		76.03
OUTPATIENT SERVICE COST CENTERS			
88.00 RURAL HEALTH CLINIC	08800		88.00
90.00 CLINIC	09000		90.00
91.00 EMERGENCY	09100		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
OTHER REIMBURSABLE COST CENTERS			
95.00 AMBULANCE SERVICES	09500		95.00
96.00 DURABLE MEDICAL EQUIP. - RENTED	09600		96.00
SPECIAL PURPOSE COST CENTERS			
118.00 SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS			
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
191.00 RESEARCH	19100		191.00
192.00 PHYSICIANS' PRIVATE OFFICES	19200		192.00
193.00 NONPAID WORKERS	19300		193.00
193.01 OTHER NON-REIMBURSABLE SENIOR CIRCLE	19301		193.01
194.00 OTHER NON-REIMBURSABLE	07950		194.00
194.01 OTHER NONREIMBURSABLE MARKETING	07953		194.01
194.02 OTHER NONREIMBURSABLE COST CENTERS	07952		194.02
200.00 TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet A-6

Date/Time Prepared:
9/30/2013 8:52 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
B - RECLASS OF EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS	4.00	0	3,977,740	1.00
	TOTALS		0	3,977,740	
C - RECLASS OF OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	60,281	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
	TOTALS		0	60,281	
D - RECLASS OF LEASE/RENTAL EXPENSES					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,302,372	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
16.00		0.00	0	0	16.00
	TOTALS		0	2,302,372	
E - RECLASS OF OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	398,222	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8,991	2.00
	TOTALS		0	407,213	
F - RECLASS OF MARKETING DEPARTMENT					
1.00	OTHER NONREIMBURSABLE MARKETING	194.01	83,881	369,192	1.00
	TOTALS		83,881	369,192	
G - RECLASS OF MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,777,959	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,572,779	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	4,350,738	
H - RECLASS OF COST OF DRUGS/IV SOLUTION					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,840,539	1.00
	TOTALS		0	3,840,539	
I - RECLASS OF LABOR AND DELIVERY COSTS					
1.00		0.00	0	0	1.00
2.00	NURSERY	43.00	152,371	28,849	2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	134,746	102,131	3.00
	TOTALS		287,117	130,980	
K - RECLASS OF NURSING ADMIN COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	754,282	229,627	1.00
	TOTALS		754,282	229,627	
L - RECLASS OF MISC DEPARTMENTS					
1.00	OPERATING ROOM	50.00	302,349	52,454	1.00
2.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	29,757	963,066	2.00
3.00	EMERGENCY	91.00	61,948	56,771	3.00
	TOTALS		394,054	1,072,291	
M - RECLASS OF DIETARY COST TO CAFETERIA					
1.00	CAFETERIA	11.00	263,552	284,292	1.00
	TOTALS		263,552	284,292	
N - RECLASS OF ER CLERK SALARIES					
1.00	EMERGENCY	91.00	172,903	0	1.00
	TOTALS		172,903	0	
500.00	Grand Total: Increases		1,955,789	17,025,265	500.00

RECLASSIFICATIONS

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet A-6
Date/Time Prepared:
9/30/2013 8:52 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
B - RECLASS OF EMPLOYEE BENEFITS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,977,740	0		1.00
	TOTALS		0	3,977,740			
C - RECLASS OF OXYGEN COSTS							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	82	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	54,639	0		2.00
3.00	ELECTROCARDIOLOGY	69.00	0	1,629	0		3.00
4.00	LABORATORY	60.00	0	70	0		4.00
5.00	WOUND CARE	76.03	0	3,861	0		5.00
	TOTALS		0	60,281			
D - RECLASS OF LEASE/RENTAL EXPENSES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,238,510	10		1.00
2.00	DIETARY	10.00	0	644	10		2.00
3.00	PHARMACY	15.00	0	147,116	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	4,095	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	1,251	0		5.00
6.00	OPERATING ROOM	50.00	0	277,273	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	14,909	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	150,513	0		8.00
9.00	ULTRASOUND	54.01	0	56,385	0		9.00
10.00	CT SCAN	57.00	0	195,195	0		10.00
11.00	MRI	58.00	0	63,790	0		11.00
12.00	LABORATORY	60.00	0	73,840	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	68,538	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	6,497	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	3,202	0		15.00
16.00	DURABLE MEDICAL EQUIP. - RENTED	96.00	0	614	0		16.00
	TOTALS		0	2,302,372			
E - RECLASS OF OTHER CAPITAL COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	407,213	10		1.00
2.00		0.00	0	0	10		2.00
	TOTALS		0	407,213			
F - RECLASS OF MARKETING DEPARTMENT							
1.00	ADMINISTRATIVE & GENERAL	5.00	83,881	369,192	0		1.00
	TOTALS		83,881	369,192			
G - RECLASS OF MEDICAL SUPPLIES							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	4,167,418	0		1.00
2.00	OPERATING ROOM	50.00	0	7,582	0		2.00
3.00	ELECTROCARDIOLOGY	69.00	0	175,738	0		3.00
	TOTALS		0	4,350,738			
H - RECLASS OF COST OF DRUGS/IV SOLUTION							
1.00	PHARMACY	15.00	0	3,840,539	0		1.00
	TOTALS		0	3,840,539			
I - RECLASS OF LABOR AND DELIVERY COSTS							
1.00	ADULTS & PEDIATRICS	30.00	287,117	130,980	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		287,117	130,980			
K - RECLASS OF NURSING ADMIN COSTS							
1.00	NURSING ADMINISTRATION	13.00	754,282	229,627	0		1.00
	TOTALS		754,282	229,627			
L - RECLASS OF MISC DEPARTMENTS							
1.00	RECOVERY ROOM	51.00	302,349	52,454	0		1.00
2.00	LABORATORY	60.00	29,757	963,066	0		2.00
3.00	AMBULANCE SERVICES	95.00	61,948	56,771	0		3.00
	TOTALS		394,054	1,072,291			
M - RECLASS OF DIETARY COST TO CAFETERIA							
1.00	DIETARY	10.00	263,552	284,292	0		1.00
	TOTALS		263,552	284,292			
N - RECLASS OF ER CLERK SALARIES							
1.00	ADMINISTRATIVE & GENERAL	5.00	172,903	0	0		1.00
	TOTALS		172,903	0			
500.00	Grand Total: Decreases		1,955,789	17,025,265			500.00

RECLASSIFICATIONS

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
9/30/2013 8:52 am

Increases			Decreases			
Cost Center	Line #	Salary	Cost Center	Line #	Salary	
2.00	3.00	4.00	6.00	7.00	8.00	
B - RECLASS OF EMPLOYEE BENEFITS						
1.00	EMPLOYEE BENEFITS	4.00	ADMINISTRATIVE & GENERAL	5.00	0	1.00
	TOTALS		TOTALS		0	
C - RECLASS OF OXYGEN COSTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	CENTRAL SERVICES & SUPPLY	14.00	0	1.00
2.00		0.00	RESPIRATORY THERAPY	65.00	0	2.00
3.00		0.00	ELECTROCARDIOLOGY	69.00	0	3.00
4.00		0.00	LABORATORY	60.00	0	4.00
5.00		0.00	WOUND CARE	76.03	0	5.00
	TOTALS		TOTALS		0	
D - RECLASS OF LEASE/RENTAL EXPENSES						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	ADMINISTRATIVE & GENERAL	5.00	0	1.00
2.00		0.00	DIETARY	10.00	0	2.00
3.00		0.00	PHARMACY	15.00	0	3.00
4.00		0.00	ADULTS & PEDIATRICS	30.00	0	4.00
5.00		0.00	INTENSIVE CARE UNIT	31.00	0	5.00
6.00		0.00	OPERATING ROOM	50.00	0	6.00
7.00		0.00	ANESTHESIOLOGY	53.00	0	7.00
8.00		0.00	RADIOLOGY-DIAGNOSTIC	54.00	0	8.00
9.00		0.00	ULTRASOUND	54.01	0	9.00
10.00		0.00	CT SCAN	57.00	0	10.00
11.00		0.00	MRI	58.00	0	11.00
12.00		0.00	LABORATORY	60.00	0	12.00
13.00		0.00	RESPIRATORY THERAPY	65.00	0	13.00
14.00		0.00	PHYSICAL THERAPY	66.00	0	14.00
15.00		0.00	ELECTROCARDIOLOGY	69.00	0	15.00
16.00		0.00	DURABLE MEDICAL EQUIP. - RENTED	96.00	0	16.00
	TOTALS		TOTALS		0	
E - RECLASS OF OTHER CAPITAL COSTS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	ADMINISTRATIVE & GENERAL	5.00	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00		0.00	0	2.00
	TOTALS		TOTALS		0	
F - RECLASS OF MARKETING DEPARTMENT						
1.00	OTHER NONREIMBURSABLE MARKETING	194.01	ADMINISTRATIVE & GENERAL	5.00	83,881	1.00
	TOTALS		TOTALS		83,881	
G - RECLASS OF MEDICAL SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	CENTRAL SERVICES & SUPPLY	14.00	0	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	OPERATING ROOM	50.00	0	2.00
3.00		0.00	ELECTROCARDIOLOGY	69.00	0	3.00
	TOTALS		TOTALS		0	
H - RECLASS OF COST OF DRUGS/IV SOLUTION						
1.00	DRUGS CHARGED TO PATIENTS	73.00	PHARMACY	15.00	0	1.00
	TOTALS		TOTALS		0	
I - RECLASS OF LABOR AND DELIVERY COSTS						
1.00		0.00	ADULTS & PEDIATRICS	30.00	287,117	1.00
2.00	NURSERY	43.00		0.00	0	2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00		0.00	0	3.00
	TOTALS		TOTALS		287,117	
K - RECLASS OF NURSING ADMIN COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	NURSING ADMINISTRATION	13.00	754,282	1.00
	TOTALS		TOTALS		754,282	
L - RECLASS OF MISC DEPARTMENTS						
1.00	OPERATING ROOM	50.00	RECOVERY ROOM	51.00	302,349	1.00
2.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	LABORATORY	60.00	29,757	2.00
3.00	EMERGENCY	91.00	AMBULANCE SERVICES	95.00	61,948	3.00
	TOTALS		TOTALS		394,054	
M - RECLASS OF DIETARY COST TO CAFETERIA						
1.00	CAFETERIA	11.00	DIETARY	10.00	263,552	1.00
	TOTALS		TOTALS		263,552	
N - RECLASS OF ER CLERK SALARIES						
1.00	EMERGENCY	91.00	ADMINISTRATIVE & GENERAL	5.00	172,903	1.00
	TOTALS		TOTALS		172,903	
500.00	Grand Total: Increases		Grand Total: Decreases		1,955,789	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet A-7
Part I
Date/Time Prepared:
9/30/2013 8:52 am

	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	1,393,859	0	0	0	1.00
2.00	Land Improvements	579,177	0	0	0	2.00
3.00	Buildings and Fixtures	42,137,067	4,820,252	0	4,820,252	3.00
4.00	Building Improvements	2,608,855	517,040	0	517,040	4.00
5.00	Fixed Equipment	2,291,474	376,709	0	376,709	5.00
6.00	Movable Equipment	32,695,622	2,696,122	0	2,696,122	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	81,706,054	8,410,123	0	8,410,123	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	81,706,054	8,410,123	0	8,410,123	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,393,859	0			1.00
2.00	Land Improvements	579,177	0			2.00
3.00	Buildings and Fixtures	46,957,319	0			3.00
4.00	Building Improvements	3,058,970	0			4.00
5.00	Fixed Equipment	2,181,278	0			5.00
6.00	Movable Equipment	28,559,232	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	82,729,835	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	82,729,835	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet A-7
Part II
Date/Time Prepared:
9/30/2013 8:52 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	1,012,006	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,695,445	221,190	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,707,451	221,190	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	1,012,006				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,916,635				2.00
3.00	Total (sum of lines 1-2)	0	3,928,641				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet A-7
Part III
Date/Time Prepared:
9/30/2013 8:52 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,405,052	390,478	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,948,282	2,532,553	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,353,334	2,923,031	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	286,007	0	0	0	2,081,537	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	30,465	0	0	0	5,511,300	2.00
3.00	Total (sum of lines 1-2)	316,472	0	0	0	7,592,837	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet A-8

Date/Time Prepared:
9/30/2013 8:52 am

Line #	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.	Ref.
				Cost Center	Line #		
				3.00	4.00		
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)	B	-7,744		CAP REL COSTS-BLDG & FIXT	1.00	10 6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-41,779		ADMINISTRATIVE & GENERAL	5.00	0 7.00
8.00	Television and radio service (chapter 21)	A	-5,209		OPERATION OF PLANT	7.00	0 8.00
9.00	Parking lot (chapter 21)			0		0.00	0 9.00
10.00	Provider-based physician adjustment	A-8-2	-8,880,302				0 10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-163		RADIOLOGY-DIAGNOSTIC	54.00	0 11.00
12.00	Related organization transactions (chapter 10)	A-8-1	6,485,507				0 12.00
13.00	Laundry and linen service			0		0.00	0 13.00
14.00	Cafeteria-employees and guests	B	-443,134		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			0		0.00	0 16.00
17.00	Sale of drugs to other than patients	B	-3,597		DRUGS CHARGED TO PATIENTS	73.00	0 17.00
18.00	Sale of medical records and abstracts	B	-4,120		MEDICAL RECORDS & LIBRARY	16.00	0 18.00
19.00	Nursing school (tuition, fees, books, etc.)	B	1,135		NURSING ADMINISTRATION	13.00	0 19.00
20.00	Vending machines	B	-1,231		ADMINISTRATIVE & GENERAL	5.00	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			RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3			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	A	393,046		CAP REL COSTS-BLDG & FIXT	1.00	9 26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	289,789		CAP REL COSTS-MVBLE EQUIP	2.00	9 27.00
28.00	Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant			0		0.00	0 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3			OCCUPATIONAL THERAPY	67.00	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3			SPEECH PATHOLOGY	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0		0.00	0 32.00
33.00	MISCELLANEOUS REVENUE	B	-10,861		ADMINISTRATIVE & GENERAL	5.00	0 33.00
33.01	EMPLOYEE GIFTS	A	-6,683		ADMINISTRATIVE & GENERAL	5.00	0 33.01
33.02	HOSPITAL BAD DEBT	A	-10,889,133		ADMINISTRATIVE & GENERAL	5.00	0 33.02
33.03	PATIENT PHONE BENEFIT EXPENSE	A	-1,602		EMPLOYEE BENEFITS	4.00	0 33.03

Provider CCN: 140184

Period:
 From 05/01/2012
 To 04/30/2013

Worksheet A-8

Date/Time Prepared:
 9/30/2013 8:52 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
33.04 PATIENT PHONE DEPRECIATION EXPENSE	A	-9,678	CAP REL COSTS-MVBLE EQUIP	2.00	9 33.04
33.05 PATIENT TV DEPRECIATION EXPENSE	A	-27,274	CAP REL COSTS-MVBLE EQUIP	2.00	9 33.05
33.06 MARKETING EXPENSES	A	-4,067	ADMINISTRATIVE & GENERAL	5.00	0 33.06
33.07 DUES	A	-4,920	ADMINISTRATIVE & GENERAL	5.00	0 33.07
33.08 PHYSICIAN RECRUITING	A	-316,498	ADMINISTRATIVE & GENERAL	5.00	0 33.08
33.09 LOBBYING EXPENSE	A	-25,351	ADMINISTRATIVE & GENERAL	5.00	0 33.09
33.10 CHARITABLE CONTRIBUTIONS	A	-2,256	ADMINISTRATIVE & GENERAL	5.00	0 33.10
33.11 GIFT SHOP	A	-61	ADMINISTRATIVE & GENERAL	5.00	0 33.11
33.12 ILLINOIS PROVIDER TAX	A	-2,248,440	ADMINISTRATIVE & GENERAL	5.00	0 33.12
33.13 CRNA COST	A	-120,272	ANESTHESIOLOGY	53.00	0 33.13
33.14 LEGAL COSTS	A	-93,056	ADMINISTRATIVE & GENERAL	5.00	0 33.14
33.15 PENALTIES/LATE CHARGES	A	-66	ADMINISTRATIVE & GENERAL	5.00	0 33.15
33.16 STAFF RELATED EXPENSE	A	-4,120	ADMINISTRATIVE & GENERAL	5.00	0 33.16
33.17 POLITICAL CONTRIBUTIONS	A	-750	ADMINISTRATIVE & GENERAL	5.00	0 33.17
33.19 PRINTING REVENUE	A	-26	ADMINISTRATIVE & GENERAL	5.00	0 33.19
33.21 PHOTO COMMISSION	A	-309	ADMINISTRATIVE & GENERAL	5.00	0 33.21
33.23 MISC NON-PATIENT REVENUE	A	-8,923	ADMINISTRATIVE & GENERAL	5.00	0 33.23
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-15,992,148			50.00

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

Provider CCN: 140184

Period: From 05/01/2012 To 04/30/2013

Worksheet A-8-1

Date/Time Prepared: 9/30/2013 8:52 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL RELAT INTEREST	214,527	0 1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	PASI OPERATING COSTS	417,000	0 2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS	34,873	0 3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAP BLDG & FIXTURES	36,607	0 4.00
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL MOVEABLE EQUIP	211,906	0 4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	NON CAPITAL HOME OFFICE COSTS	1,742,748	0 4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE	1,270,480	1,508,637 4.03
4.04	2.00	CAP REL COSTS-MVBLE EQUIP	CIG LEASED EQUIPMENT	39,749	221,190 4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	0	-6,969,171 4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	1,044,369 4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	401K FEES	0	2,710 4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	AUDIT FEES	0	53,408 4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	MIS FEES	0	652,085 4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	MANAGED CARE	0	27,553 4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	CASE MANAGEMENT	0	116,883 4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	PURCHASE AND ANCILLARY	0	9,577 4.12
4.13	5.00	ADMINISTRATIVE & GENERAL	EMERGENCY ROOM	0	59,413 4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	PPSI FEES	0	16,149 4.14
4.15	5.00	ADMINISTRATIVE & GENERAL	COMPLIANCE/HIM/CCA FEES	0	34,312 4.15
4.16	5.00	ADMINISTRATIVE & GENERAL	SENIOR CIRCLE	0	21,865 4.16
4.17	5.00	ADMINISTRATIVE & GENERAL	PASI COLLECTION FEES	0	508,098 4.17
4.18	5.00	ADMINISTRATIVE & GENERAL	EBOS FEES	0	63,616 4.18
4.19	5.00	ADMINISTRATIVE & GENERAL	PASI LIEN COLLECTION FEES	0	111,689 4.19
5.00	0		0	3,967,890	-2,517,617 5.00

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

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

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

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

6.00	B		0.00	CHS, INC	100.00	6.00
7.00	B		0.00	PASI	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet A-8-1

Date/Time Prepared:
9/30/2013 8:52 am

	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	214,527	11		1.00
2.00	417,000	0		2.00
3.00	34,873	11		3.00
4.00	36,607	11		4.00
4.01	211,906	11		4.01
4.02	1,742,748	0		4.02
4.03	-238,157	0		4.03
4.04	-181,441	11		4.04
4.05	6,969,171	0		4.05
4.06	-1,044,369	0		4.06
4.07	-2,710	0		4.07
4.08	-53,408	0		4.08
4.09	-652,085	0		4.09
4.10	-27,553	0		4.10
4.11	-116,883	0		4.11
4.12	-9,577	0		4.12
4.13	-59,413	0		4.13
4.14	-16,149	0		4.14
4.15	-34,312	0		4.15
4.16	-21,865	0		4.16
4.17	-508,098	0		4.17
4.18	-63,616	0		4.18
4.19	-111,689	0		4.19
5.00	6,485,507			5.00

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

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

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

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

6.00	HOSPITAL CORPOR		6.00
7.00	COLLECTION AGEN		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet A-8-2

Date/Time Prepared:
9/30/2013 8:52 am

Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours
1.00	2.00	3.00	4.00	5.00	6.00	7.00
1.00	13.00 NURSING ADMINISTRATION	1,380	1,380	0	142,500	0
2.00	30.00 ADULTS & PEDIATRICS	927,090	927,090	0	142,500	0
3.00	50.00 OPERATING ROOM	916,950	916,950	0	182,900	0
4.00	53.00 ANESTHESIOLOGY	4,169,800	4,169,800	0	167,500	0
5.00	54.00 RADIOLOGY-DIAGNOSTIC	694,525	694,525	0	217,600	0
6.00	69.00 ELECTROCARDIOLOGY	503,338	503,338	0	142,500	0
7.00	76.01 SLEEP LAB	208,656	208,656	0	142,500	0
8.00	91.00 EMERGENCY	1,457,484	1,457,484	0	142,500	0
9.00	5.00 ADMINISTRATIVE & GENERAL	-1	-1	0	142,500	0
10.00	60.00 LABORATORY	1,080	1,080	0	142,500	0
200.00		8,880,302	8,880,302	0		0

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	13.00 NURSING ADMINISTRATION	0	0	0	0	0
2.00	30.00 ADULTS & PEDIATRICS	0	0	0	0	0
3.00	50.00 OPERATING ROOM	0	0	0	0	0
4.00	53.00 ANESTHESIOLOGY	0	0	0	0	0
5.00	54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
6.00	69.00 ELECTROCARDIOLOGY	0	0	0	0	0
7.00	76.01 SLEEP LAB	0	0	0	0	0
8.00	91.00 EMERGENCY	0	0	0	0	0
9.00	5.00 ADMINISTRATIVE & GENERAL	0	0	0	0	0
10.00	60.00 LABORATORY	0	0	0	0	0
200.00		0	0	0	0	0

Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment
1.00	2.00	15.00	16.00	17.00	18.00
1.00	13.00 NURSING ADMINISTRATION	0	0	0	1,380
2.00	30.00 ADULTS & PEDIATRICS	0	0	0	927,090
3.00	50.00 OPERATING ROOM	0	0	0	916,950
4.00	53.00 ANESTHESIOLOGY	0	0	0	4,169,800
5.00	54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	694,525
6.00	69.00 ELECTROCARDIOLOGY	0	0	0	503,338
7.00	76.01 SLEEP LAB	0	0	0	208,656
8.00	91.00 EMERGENCY	0	0	0	1,457,484
9.00	5.00 ADMINISTRATIVE & GENERAL	0	0	0	-1
10.00	60.00 LABORATORY	0	0	0	1,080
200.00		0	0	0	8,880,302

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,081,537	2,081,537			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	5,511,300		5,511,300		2.00
4.00 00400	EMPLOYEE BENEFITS	4,368,349	10,252	27,145	4,405,746	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	10,476,460	270,599	716,468	640,636	12,104,163
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	2,183,104	434,925	1,151,550	62,663	3,832,242
8.00 00800	LAUNDRY & LINEN SERVICE	306,532	4,210	11,146	7,214	329,102
9.00 00900	HOUSEKEEPING	1,086,455	15,081	39,931	163,854	1,305,321
10.00 01000	DIETARY	991,917	31,105	82,356	89,100	1,194,478
11.00 01100	CAFETERIA	104,710	35,153	93,075	49,179	282,117
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	779,607	48,461	128,310	123,820	1,080,198
14.00 01400	CENTRAL SERVICES & SUPPLY	414,349	19,783	52,380	26,091	512,603
15.00 01500	PHARMACY	1,233,919	17,984	47,616	211,696	1,511,215
16.00 01600	MEDICAL RECORDS & LIBRARY	932,596	29,110	77,076	84,389	1,123,171
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	5,120,397	313,951	831,250	752,661	7,018,259
31.00 03100	INTENSIVE CARE UNIT	2,410,584	103,915	275,136	379,213	3,168,848
43.00 04300	NURSERY	618,212	16,855	44,628	89,172	768,867
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	3,392,728	174,229	461,309	303,319	4,331,585
51.00 05100	RECOVERY ROOM	0	0	0	0	0
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,015,034	40,653	107,636	150,208	1,313,531
53.00 05300	ANESTHESIOLOGY	187,316	5,050	13,370	0	205,736
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,364,305	61,870	163,814	264,942	2,854,931
54.01 05401	ULTRASOUND	182,846	17,704	46,875	30,100	277,525
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
56.00 05600	RADIOISOTOPE	434,741	5,865	15,528	27,566	483,700
57.00 05700	CT SCAN	370,846	10,201	27,010	55,920	463,977
58.00 05800	MRI	121,192	10,838	28,696	10,481	171,207
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 06000	LABORATORY	2,451,331	40,211	106,468	189,294	2,787,304
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	992,823	2,139	5,663	5,553	1,006,178
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	571,802	9,217	24,404	85,094	690,517
66.00 06600	PHYSICAL THERAPY	537,878	55,547	147,073	83,626	824,124
67.00 06700	OCCUPATIONAL THERAPY	68,448	1,400	3,708	11,835	85,391
68.00 06800	SPEECH PATHOLOGY	75,291	789	2,090	13,027	91,197
69.00 06900	ELECTROCARDIOLOGY	1,651,327	35,561	94,154	144,856	1,925,898
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,838,240	0	0	0	1,838,240
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	2,572,779	0	0	0	2,572,779
73.00 07300	DRUGS CHARGED TO PATIENTS	3,836,942	0	0	0	3,836,942
74.00 07400	RENAL DIALYSIS	393,542	2,835	7,505	0	403,882
76.00 03020	ACUPUNCTURE	0	0	0	0	0
76.01 03021	SLEEP LAB	10,547	19,995	52,942	0	83,484
76.03 03023	WOUND CARE	97,042	22,932	60,717	10,921	191,612
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0
90.00 09000	CLINIC	0	0	0	0	0
91.00 09100	EMERGENCY	2,269,037	80,949	214,329	314,712	2,879,027
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0
96.00 09600	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	64,056,065	1,949,369	5,161,358	4,381,142	63,549,351
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,053	5,737	15,190	0	27,980
191.00 19100	RESEARCH	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	125,336	331,853	0	457,189
193.00 19300	NONPAID WORKERS	0	0	0	0	0
193.01 19301	OTHER NON-REIMBURSABLE SENIOR CIRCLE	60,086	1,095	2,899	8,952	73,032
194.00 07950	OTHER NON-REIMBURSABLE	0	0	0	0	0
194.01 07953	OTHER NONREIMBURSABLE MARKETING	453,073	0	0	15,652	468,725
194.02 07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
200.00	Cross Foot Adjustments	0	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
201.00 Negative Cost Centers		0	0	0		201.00
202.00 TOTAL (sum lines 118-201)	64,576,277	2,081,537	5,511,300	4,405,746	64,576,277	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet B
Part I
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
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
5.00	00500	ADMINISTRATIVE & GENERAL	12,104,163					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	884,014	0	4,716,256			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	75,917	0	14,536	419,555		8.00
9.00	00900	HOUSEKEEPING	301,109	0	52,079	0	1,658,509	9.00
10.00	01000	DIETARY	275,540	0	107,411	0	38,379	10.00
11.00	01100	CAFETERIA	65,078	0	121,391	0	43,374	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	249,178	0	167,345	0	59,793	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	118,246	0	68,315	4,315	24,409	14.00
15.00	01500	PHARMACY	348,604	0	62,102	0	22,189	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	259,091	0	100,524	0	35,918	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,618,956	0	1,084,139	186,713	387,365	30.00
31.00	03100	INTENSIVE CARE UNIT	730,984	0	358,839	34,022	128,215	31.00
43.00	04300	NURSERY	177,361	0	58,204	0	20,797	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	999,201	0	601,651	66,090	212,145	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	303,003	0	140,382	0	50,159	52.00
53.00	05300	ANESTHESIOLOGY	47,459	0	17,438	0	6,231	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	658,570	0	213,651	12,833	76,338	54.00
54.01	05401	ULTRASOUND	64,019	0	61,135	0	21,844	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	111,579	0	20,251	0	7,236	56.00
57.00	05700	CT SCAN	107,029	0	35,227	0	12,587	57.00
58.00	05800	MRI	39,494	0	37,425	0	13,372	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	642,970	0	138,858	0	49,615	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	232,103	0	7,385	0	2,639	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	159,287	0	31,828	0	11,372	65.00
66.00	06600	PHYSICAL THERAPY	190,107	0	191,817	8,499	68,537	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,698	0	4,836	0	1,728	67.00
68.00	06800	SPEECH PATHOLOGY	21,037	0	2,726	0	974	68.00
69.00	06900	ELECTROCARDIOLOGY	444,262	0	122,798	42,780	43,876	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	424,042	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	593,484	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	885,098	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	93,167	0	9,789	0	3,498	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03021	SLEEP LAB	19,258	0	69,048	0	24,671	76.01
76.03	03023	WOUND CARE	44,201	0	79,188	35	28,294	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	664,128	0	279,534	64,268	99,879	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,867,274	0	4,259,852	419,555	1,495,434	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,454	0	19,812	0	7,079	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	105,463	0	432,811	0	154,645	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	OTHER NON-REIMBURSABLE SENIOR CIRCLE	16,847	0	3,781	0	1,351	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	OTHER NONREIMBURSABLE MARKETING	108,125	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	12,104,163	0	4,716,256	419,555	1,658,509	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

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Part I
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Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	1,615,808					10.00
11.00	01100	664,291	1,176,251				11.00
12.00	01200	0	0	0			12.00
13.00	01300	0	23,626	0	1,580,140		13.00
14.00	01400	0	20,532	0	0	748,420	14.00
15.00	01500	0	48,090	0	0	3,841	15.00
16.00	01600	0	49,437	0	0	233	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	271,867	280,057	0	573,327	44,686	30.00
31.00	03100	58,075	110,887	0	288,864	15,666	31.00
43.00	04300	0	27,885	0	67,926	7,234	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	110,413	0	231,052	101,661	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	47,544	0	114,420	1,153	52.00
53.00	05300	0	0	0	0	14,043	53.00
54.00	05400	0	86,205	0	0	3,648	54.00
54.01	05401	0	9,501	0	0	266	54.01
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	7,645	0	0	996	56.00
57.00	05700	0	19,986	0	0	3,828	57.00
58.00	05800	0	3,568	0	0	60	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	93,704	0	0	65,068	60.00
62.00	06200	0	1,966	0	0	0	62.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	35,057	0	64,820	5,638	65.00
66.00	06600	0	25,738	0	0	1,360	66.00
67.00	06700	0	2,912	0	0	0	67.00
68.00	06800	0	2,912	0	0	0	68.00
69.00	06900	0	49,036	0	0	33,874	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	216,403	71.00
72.00	07200	0	0	0	0	204,144	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03020	0	0	0	0	0	76.00
76.01	03021	0	0	0	0	348	76.01
76.03	03023	0	3,713	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	108,884	0	239,731	24,169	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
96.00	09600	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
118.00		994,233	1,169,298	0	1,580,140	748,319	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	621,575	3,531	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	3,422	0	0	101	193.01
194.00	07950	0	0	0	0	0	194.00
194.01	07953	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		1,615,808	1,176,251	0	1,580,140	748,420	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	1,996,041					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,568,374				16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	109,460	11,574,829	0	11,574,829	30.00
31.00	03100	INTENSIVE CARE UNIT	0	40,421	4,934,821	0	4,934,821	31.00
43.00	04300	NURSERY	0	7,755	1,136,029	0	1,136,029	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	220,335	6,874,133	0	6,874,133	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	10,914	1,981,106	0	1,981,106	52.00
53.00	05300	ANESTHESIOLOGY	0	55,468	346,375	0	346,375	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	45,044	3,951,220	0	3,951,220	54.00
54.01	05401	ULTRASOUND	0	15,760	450,050	0	450,050	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	51,008	682,415	0	682,415	56.00
57.00	05700	CT SCAN	0	88,166	730,800	0	730,800	57.00
58.00	05800	MRI	0	14,066	279,192	0	279,192	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	233,797	4,011,316	0	4,011,316	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	14,418	1,264,689	0	1,264,689	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	46,678	1,045,197	0	1,045,197	65.00
66.00	06600	PHYSICAL THERAPY	0	22,493	1,332,675	0	1,332,675	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,878	117,443	0	117,443	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,855	120,701	0	120,701	68.00
69.00	06900	ELECTROCARDIOLOGY	0	145,863	2,808,387	0	2,808,387	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	81,265	2,559,950	0	2,559,950	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	68,412	3,438,819	0	3,438,819	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,996,041	145,512	6,863,593	0	6,863,593	73.00
74.00	07400	RENAL DIALYSIS	0	6,741	517,077	0	517,077	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03021	SLEEP LAB	0	4,749	201,558	0	201,558	76.01
76.03	03023	WOUND CARE	0	2	347,045	0	347,045	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	135,314	4,494,934	0	4,494,934	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,996,041	1,568,374	62,064,354	0	62,064,354	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	61,325	0	61,325	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,775,214	0	1,775,214	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	OTHER NON-REIMBURSABLE SENIOR CIRCLE	0	0	98,534	0	98,534	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	OTHER NONREIMBURSABLE MARKETING	0	0	576,850	0	576,850	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,996,041	1,568,374	64,576,277	0	64,576,277	202.00

COST ALLOCATION STATISTICS

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet Non-CMS W
Date/Time Prepared:
9/30/2013 8:52 am

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	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS	3	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM. COST	5.00
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	4	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	5	SQUARE FOOTAGE	9.00
10.00	DIETARY	6	MEALS SERVED	10.00
11.00	CAFETERIA	7	FTE'S	11.00
12.00	MAINTENANCE OF PERSONNEL	8	NUMBER HOUSED	12.00
13.00	NURSING ADMINISTRATION	9	NURSING WA GES	13.00
14.00	CENTRAL SERVICES & SUPPLY	10	COSTED REQUIS.	14.00
15.00	PHARMACY	11	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	12	GROSS CHAR GES	16.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet B
Part II
Date/Time Prepared:
9/30/2013 8:52 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS		
		BLDG & FIXT	MVBLE EQUIP				
		0	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	10,252	27,145	37,397	37,397	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	270,599	716,468	987,067	5,438	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	0	434,925	1,151,550	1,586,475	532	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	4,210	11,146	15,356	61	8.00
9.00 00900	HOUSEKEEPING	0	15,081	39,931	55,012	1,391	9.00
10.00 01000	DIETARY	0	31,105	82,356	113,461	756	10.00
11.00 01100	CAFETERIA	0	35,153	93,075	128,228	417	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	0	48,461	128,310	176,771	1,051	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	19,783	52,380	72,163	221	14.00
15.00 01500	PHARMACY	0	17,984	47,616	65,600	1,797	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	29,110	77,076	106,186	716	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	313,951	831,250	1,145,201	6,387	30.00
31.00 03100	INTENSIVE CARE UNIT	0	103,915	275,136	379,051	3,219	31.00
43.00 04300	NURSERY	0	16,855	44,628	61,483	757	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	174,229	461,309	635,538	2,575	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	40,653	107,636	148,289	1,275	52.00
53.00 05300	ANESTHESIOLOGY	0	5,050	13,370	18,420	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	61,870	163,814	225,684	2,249	54.00
54.01 05401	ULTRASOUND	0	17,704	46,875	64,579	256	54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 05600	RADIOISOTOPE	0	5,865	15,528	21,393	234	56.00
57.00 05700	CT SCAN	0	10,201	27,010	37,211	475	57.00
58.00 05800	MRI	0	10,838	28,696	39,534	89	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	0	40,211	106,468	146,679	1,607	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	2,139	5,663	7,802	47	62.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	9,217	24,404	33,621	722	65.00
66.00 06600	PHYSICAL THERAPY	0	55,547	147,073	202,620	710	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	1,400	3,708	5,108	100	67.00
68.00 06800	SPEECH PATHOLOGY	0	789	2,090	2,879	111	68.00
69.00 06900	ELECTROCARDIOLOGY	0	35,561	94,154	129,715	1,230	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
74.00 07400	RENAL DIALYSIS	0	2,835	7,505	10,340	0	74.00
76.00 03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01 03021	SLEEP LAB	0	19,995	52,942	72,937	0	76.01
76.03 03023	WOUND CARE	0	22,932	60,717	83,649	93	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00 09000	CLINIC	0	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	80,949	214,329	295,278	2,672	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00 09600	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,949,369	5,161,358	7,110,727	37,188	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,737	15,190	20,927	0	190.00
191.00 19100	RESEARCH	0	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	125,336	331,853	457,189	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01 19301	OTHER NON-REIMBURSABLE SENIOR CIRCLE	0	1,095	2,899	3,994	76	193.01
194.00 07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01 07953	OTHER NONREIMBURSABLE MARKETING	0	0	0	0	133	194.01
194.02 07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments				0	0	200.00
201.00	Negative Cost Centers		0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet B
Part II
Date/Time Prepared:
9/30/2013 8:52 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	2A	4.00	
202.00 TOTAL (sum lines 118-201)	0	2,081,537	5,511,300	7,592,837	37,397	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet B
Part II
Date/Time Prepared:
9/30/2013 8:52 am

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	992,505					5.00
6.00	00600	0	0				6.00
7.00	00700	72,487	0	1,659,494			7.00
8.00	00800	6,225	0	5,115	26,757		8.00
9.00	00900	24,690	0	18,325	0	99,418	9.00
10.00	01000	22,594	0	37,795	0	2,301	10.00
11.00	01100	5,336	0	42,713	0	2,600	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	20,432	0	58,883	0	3,584	13.00
14.00	01400	9,696	0	24,038	275	1,463	14.00
15.00	01500	28,585	0	21,852	0	1,330	15.00
16.00	01600	21,245	0	35,371	0	2,153	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	132,748	0	381,470	11,908	23,220	30.00
31.00	03100	59,939	0	126,264	2,170	7,686	31.00
43.00	04300	14,543	0	20,480	0	1,247	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	81,932	0	211,701	4,215	12,717	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	24,845	0	49,396	0	3,007	52.00
53.00	05300	3,891	0	6,136	0	373	53.00
54.00	05400	54,001	0	75,177	818	4,576	54.00
54.01	05401	5,249	0	21,511	0	1,309	54.01
55.00	05500	0	0	0	0	0	55.00
56.00	05600	9,149	0	7,126	0	434	56.00
57.00	05700	8,776	0	12,395	0	755	57.00
58.00	05800	3,238	0	13,169	0	802	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	52,722	0	48,860	0	2,974	60.00
62.00	06200	19,032	0	2,599	0	158	62.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	13,061	0	11,199	0	682	65.00
66.00	06600	15,588	0	67,494	542	4,108	66.00
67.00	06700	1,615	0	1,702	0	104	67.00
68.00	06800	1,725	0	959	0	58	68.00
69.00	06900	36,428	0	43,208	2,728	2,630	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	34,770	0	0	0	0	71.00
72.00	07200	48,664	0	0	0	0	72.00
73.00	07300	72,576	0	0	0	0	73.00
74.00	07400	7,639	0	3,444	0	210	74.00
76.00	03020	0	0	0	0	0	76.00
76.01	03021	1,579	0	24,296	0	1,479	76.01
76.03	03023	3,624	0	27,864	2	1,696	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	54,457	0	98,359	4,099	5,987	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
96.00	09600	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
118.00		973,081	0	1,498,901	26,757	89,643	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	529	0	6,971	0	424	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	8,648	0	152,292	0	9,270	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	1,381	0	1,330	0	81	193.01
194.00	07950	0	0	0	0	0	194.00
194.01	07953	8,866	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		992,505	0	1,659,494	26,757	99,418	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140184	Period: From 05/01/2012 To 04/30/2013	Worksheet B Part II Date/Time Prepared: 9/30/2013 8:52 am		
Cost Center	Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	176,907					10.00
11.00	01100	72,731	252,025				11.00
12.00	01200	0	0	0			12.00
13.00	01300	0	5,062	0	265,783		13.00
14.00	01400	0	4,399	0	0	112,255	14.00
15.00	01500	0	10,304	0	0	576	15.00
16.00	01600	0	10,592	0	0	35	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	29,765	60,005	0	96,437	6,703	30.00
31.00	03100	6,358	23,759	0	48,587	2,350	31.00
43.00	04300	0	5,975	0	11,425	1,085	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	23,657	0	38,863	15,248	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	10,187	0	19,245	173	52.00
53.00	05300	0	0	0	0	2,106	53.00
54.00	05400	0	18,470	0	0	547	54.00
54.01	05401	0	2,036	0	0	40	54.01
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	1,638	0	0	149	56.00
57.00	05700	0	4,282	0	0	574	57.00
58.00	05800	0	764	0	0	9	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	20,077	0	0	9,760	60.00
62.00	06200	0	421	0	0	0	62.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	7,511	0	10,903	846	65.00
66.00	06600	0	5,515	0	0	204	66.00
67.00	06700	0	624	0	0	0	67.00
68.00	06800	0	624	0	0	0	68.00
69.00	06900	0	10,507	0	0	5,081	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	32,457	71.00
72.00	07200	0	0	0	0	30,620	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03020	0	0	0	0	0	76.00
76.01	03021	0	0	0	0	52	76.01
76.03	03023	0	796	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	23,330	0	40,323	3,625	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
96.00	09600	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
118.00		108,854	250,535	0	265,783	112,240	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	68,053	757	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	733	0	0	15	193.01
194.00	07950	0	0	0	0	0	194.00
194.01	07953	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		176,907	252,025	0	265,783	112,255	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140184	Period: From 05/01/2012 To 04/30/2013	Worksheet B Part II Date/Time Prepared: 9/30/2013 8:52 am	
Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
	15.00	16.00	24.00	25.00	26.00
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS				4.00
5.00 00500	ADMINISTRATIVE & GENERAL				5.00
6.00 00600	MAINTENANCE & REPAIRS				6.00
7.00 00700	OPERATION OF PLANT				7.00
8.00 00800	LAUNDRY & LINEN SERVICE				8.00
9.00 00900	HOUSEKEEPING				9.00
10.00 01000	DIETARY				10.00
11.00 01100	CAFETERIA				11.00
12.00 01200	MAINTENANCE OF PERSONNEL				12.00
13.00 01300	NURSING ADMINISTRATION				13.00
14.00 01400	CENTRAL SERVICES & SUPPLY				14.00
15.00 01500	PHARMACY	130,044			15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	176,298		16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	0	12,314	1,906,158	30.00
31.00 03100	INTENSIVE CARE UNIT	0	4,547	663,930	31.00
43.00 04300	NURSERY	0	872	117,867	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	24,788	1,051,234	50.00
51.00 05100	RECOVERY ROOM	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	1,228	257,645	52.00
53.00 05300	ANESTHESIOLOGY	0	6,240	37,166	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	5,067	386,589	54.00
54.01 05401	ULTRASOUND	0	1,773	96,753	54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00 05600	RADIOISOTOPE	0	5,738	45,861	56.00
57.00 05700	CT SCAN	0	9,919	74,387	57.00
58.00 05800	MRI	0	1,582	59,187	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000	LABORATORY	0	26,161	308,840	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,622	31,681	62.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	5,251	83,796	65.00
66.00 06600	PHYSICAL THERAPY	0	2,530	299,311	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	324	9,577	67.00
68.00 06800	SPEECH PATHOLOGY	0	209	6,565	68.00
69.00 06900	ELECTROCARDIOLOGY	0	16,410	247,937	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,142	76,369	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,696	86,980	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	130,044	16,370	218,990	73.00
74.00 07400	RENAL DIALYSIS	0	758	22,391	74.00
76.00 03020	ACUPUNCTURE	0	0	0	76.00
76.01 03021	SLEEP LAB	0	534	100,877	76.01
76.03 03023	WOUND CARE	0	0	117,724	76.03
OUTPATIENT SERVICE COST CENTERS					
88.00 08800	RURAL HEALTH CLINIC	0	0	0	88.00
90.00 09000	CLINIC	0	0	0	90.00
91.00 09100	EMERGENCY	0	15,223	543,353	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 09500	AMBULANCE SERVICES	0	0	0	95.00
96.00 09600	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1-117)	130,044	176,298	6,851,168	118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	28,851	190.00
191.00 19100	RESEARCH	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	696,209	192.00
193.00 19300	NONPAID WORKERS	0	0	0	193.00
193.01 19301	OTHER NON-REIMBURSABLE SENIOR CIRCLE	0	0	7,610	193.01
194.00 07950	OTHER NON-REIMBURSABLE	0	0	0	194.00
194.01 07953	OTHER NONREIMBURSABLE MARKETING	0	0	8,999	194.01
194.02 07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.02
200.00	Cross Foot Adjustments	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	130,044	176,298	7,592,837	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet B-1
Date/Time Prepared:
9/30/2013 8:52 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	245,262				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		245,262			2.00
4.00 00400	EMPLOYEE BENEFITS	1,208	1,208	23,610,722		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	31,884	31,884	3,433,221	-12,104,163	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	51,246	51,246	335,815	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	496	496	38,663	0	8.00
9.00 00900	HOUSEKEEPING	1,777	1,777	878,109	0	9.00
10.00 01000	DIETARY	3,665	3,665	477,492	0	10.00
11.00 01100	CAFETERIA	4,142	4,142	263,552	0	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	5,710	5,710	663,560	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	2,331	2,331	139,822	0	14.00
15.00 01500	PHARMACY	2,119	2,119	1,134,499	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	3,430	3,430	452,248	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	36,992	36,992	4,033,536	0	30.00
31.00 03100	INTENSIVE CARE UNIT	12,244	12,244	2,032,235	0	31.00
43.00 04300	NURSERY	1,986	1,986	477,880	0	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	20,529	20,529	1,625,515	0	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	4,790	4,790	804,978	0	52.00
53.00 05300	ANESTHESIOLOGY	595	595	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	7,290	7,290	1,419,848	0	54.00
54.01 05401	ULTRASOUND	2,086	2,086	161,310	0	54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00 05600	RADIOISOTOPE	691	691	147,727	0	56.00
57.00 05700	CT SCAN	1,202	1,202	299,681	0	57.00
58.00 05800	MRI	1,277	1,277	56,166	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	4,738	4,738	1,014,444	0	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	252	252	29,757	0	62.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	1,086	1,086	456,025	0	65.00
66.00 06600	PHYSICAL THERAPY	6,545	6,545	448,157	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	165	165	63,425	0	67.00
68.00 06800	SPEECH PATHOLOGY	93	93	69,813	0	68.00
69.00 06900	ELECTROCARDIOLOGY	4,190	4,190	776,295	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	334	334	0	0	74.00
76.00 03020	ACUPUNCTURE	0	0	0	0	76.00
76.01 03021	SLEEP LAB	2,356	2,356	0	0	76.01
76.03 03023	WOUND CARE	2,702	2,702	58,526	0	76.03
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	9,538	9,538	1,686,570	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
96.00 09600	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	229,689	229,689	23,478,869	-12,104,163	51,445,188
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	676	676	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	14,768	14,768	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
193.01 19301	OTHER NON-REIMBURSABLE SENIOR CIRCLE	129	129	47,972	0	193.01
194.00 07950	OTHER NON-REIMBURSABLE	0	0	0	0	194.00
194.01 07953	OTHER NONREIMBURSABLE MARKETING	0	0	83,881	0	194.01
194.02 07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.02
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet B-1
Date/Time Prepared:
9/30/2013 8:52 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
202.00	Cost to be allocated (per Wkst. B, Part I)	2,081,537	5,511,300	4,405,746	5A	12,104,163	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	8.486994	22.471072	0.186599		0.230678	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			37,397		992,505	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001584		0.018915	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet B-1

Date/Time Prepared:
9/30/2013 8:52 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FOOTAGE)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	212,170					6.00
7.00	00700	51,246	160,924				7.00
8.00	00800	496	496	456,607			8.00
9.00	00900	1,777	1,777	0	158,381		9.00
10.00	01000	3,665	3,665	0	3,665	262,174	10.00
11.00	01100	4,142	4,142	0	4,142	107,785	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	5,710	5,710	0	5,710	0	13.00
14.00	01400	2,331	2,331	4,696	2,331	0	14.00
15.00	01500	2,119	2,119	0	2,119	0	15.00
16.00	01600	3,430	3,430	0	3,430	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	36,992	36,992	203,201	36,992	44,112	30.00
31.00	03100	12,244	12,244	37,027	12,244	9,423	31.00
43.00	04300	1,986	1,986	0	1,986	0	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	20,529	20,529	71,927	20,259	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	4,790	4,790	0	4,790	0	52.00
53.00	05300	595	595	0	595	0	53.00
54.00	05400	7,290	7,290	13,966	7,290	0	54.00
54.01	05401	2,086	2,086	0	2,086	0	54.01
55.00	05500	0	0	0	0	0	55.00
56.00	05600	691	691	0	691	0	56.00
57.00	05700	1,202	1,202	0	1,202	0	57.00
58.00	05800	1,277	1,277	0	1,277	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	4,738	4,738	0	4,738	0	60.00
62.00	06200	252	252	0	252	0	62.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	1,086	1,086	0	1,086	0	65.00
66.00	06600	6,545	6,545	9,250	6,545	0	66.00
67.00	06700	165	165	0	165	0	67.00
68.00	06800	93	93	0	93	0	68.00
69.00	06900	4,190	4,190	46,558	4,190	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	334	334	0	334	0	74.00
76.00	03020	0	0	0	0	0	76.00
76.01	03021	2,356	2,356	0	2,356	0	76.01
76.03	03023	2,702	2,702	38	2,702	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	9,538	9,538	69,944	9,538	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
96.00	09600	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
118.00		196,597	145,351	456,607	142,808	161,320	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	676	676	0	676	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	14,768	14,768	0	14,768	100,854	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	129	129	0	129	0	193.01
194.00	07950	0	0	0	0	0	194.00
194.01	07953	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00							201.00
202.00		0	4,716,256	419,555	1,658,509	1,615,808	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet B-1

Date/Time Prepared:
9/30/2013 8:52 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FOOTAGE)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	29.307350	0.918854	10.471641	6.163113	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	1,659,494	26,757	99,418	176,907	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	10.312284	0.058600	0.627714	0.674769	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet B-1
Date/Time Prepared:
9/30/2013 8:52 am

Cost Center Description		CAFETERIA (FTE'S)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (NURSING WAGES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	32,311					11.00
12.00	01200	0	0				12.00
13.00	01300	649	0	11,116,739			13.00
14.00	01400	564	0	0	8,440,326		14.00
15.00	01500	1,321	0	0	43,317	3,686,917	15.00
16.00	01600	1,358	0	0	2,626	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	7,693	0	4,033,536	503,949	0	30.00
31.00	03100	3,046	0	2,032,235	176,673	0	31.00
43.00	04300	766	0	477,880	81,584	0	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,033	0	1,625,515	1,146,488	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	1,306	0	804,978	12,998	0	52.00
53.00	05300	0	0	0	158,368	0	53.00
54.00	05400	2,368	0	0	41,140	0	54.00
54.01	05401	261	0	0	3,001	0	54.01
55.00	05500	0	0	0	0	0	55.00
56.00	05600	210	0	0	11,231	0	56.00
57.00	05700	549	0	0	43,168	0	57.00
58.00	05800	98	0	0	672	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	2,574	0	0	733,805	0	60.00
62.00	06200	54	0	0	0	0	62.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	963	0	456,025	63,587	0	65.00
66.00	06600	707	0	0	15,339	0	66.00
67.00	06700	80	0	0	0	0	67.00
68.00	06800	80	0	0	0	0	68.00
69.00	06900	1,347	0	0	382,011	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	2,440,493	0	71.00
72.00	07200	0	0	0	2,302,242	0	72.00
73.00	07300	0	0	0	0	3,686,917	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03020	0	0	0	0	0	76.00
76.01	03021	0	0	0	3,922	0	76.01
76.03	03023	102	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	2,991	0	1,686,570	272,571	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
96.00	09600	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
118.00							
		32,120	0	11,116,739	8,439,185	3,686,917	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	97	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	94	0	0	1,141	0	193.01
194.00	07950	0	0	0	0	0	194.00
194.01	07953	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet B-1

Date/Time Prepared:
9/30/2013 8:52 am

Cost Center Description		CAFETERIA (FTE'S)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (NURSING WA GES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	1,176,251	0	1,580,140	748,420	1,996,041	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	36.404042	0.000000	0.142141	0.088672	0.541385	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	252,025	0	265,783	112,255	130,044	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	7.799975	0.000000	0.023908	0.013300	0.035272	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet B-1
Date/Time Prepared:
9/30/2013 8:52 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		16.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
		455,878,179	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
		31,819,731	
		11,750,259	
		2,254,432	
		0	
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	ULTRASOUND	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03020	ACUPUNCTURE	76.00
76.01	03021	SLEEP LAB	76.01
76.03	03023	WOUND CARE	76.03
		64,050,762	
		0	
		3,172,749	
		16,124,525	
		13,094,134	
		4,581,496	
		0	
		14,827,896	
		25,629,521	
		4,089,094	
		0	
		67,919,813	
		4,191,387	
		0	
		13,569,206	
		6,538,597	
		836,593	
		539,283	
		42,402,127	
		0	
		23,623,542	
		19,887,089	
		42,300,005	
		1,959,582	
		0	
		1,380,477	
		526	
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
		0	
		0	
		39,335,353	
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	96.00
		0	
		0	
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
		455,878,179	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
193.01	19301	OTHER NON-REIMBURSABLE SENIOR CIRCLE	193.01
194.00	07950	OTHER NON-REIMBURSABLE	194.00
194.01	07953	OTHER NONREIMBURSABLE MARKETING	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	194.02
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet B-1
Date/Time Prepared:
9/30/2013 8:52 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		16.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	1,568,374	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.003440	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	176,298	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000387	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet C
Part I
Date/Time Prepared:
9/30/2013 8:52 am

		Title XVIII		Hospital		PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		11,574,829	0	11,574,829	30.00
31.00	03100 INTENSIVE CARE UNIT		4,934,821	0	4,934,821	31.00
43.00	04300 NURSERY		1,136,029	0	1,136,029	43.00
44.00	04400 SKILLED NURSING FACILITY		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		6,874,133	0	6,874,133	50.00
51.00	05100 RECOVERY ROOM		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		1,981,106	0	1,981,106	52.00
53.00	05300 ANESTHESIOLOGY		346,375	0	346,375	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		3,951,220	0	3,951,220	54.00
54.01	05401 ULTRASOUND		450,050	0	450,050	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC		0	0	0	55.00
56.00	05600 RADIOISOTOPE		682,415	0	682,415	56.00
57.00	05700 CT SCAN		730,800	0	730,800	57.00
58.00	05800 MRI		279,192	0	279,192	58.00
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	06000 LABORATORY		4,011,316	0	4,011,316	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		1,264,689	0	1,264,689	62.00
64.00	06400 INTRAVENOUS THERAPY		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	1,045,197	0	1,045,197	65.00
66.00	06600 PHYSICAL THERAPY	0	1,332,675	0	1,332,675	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	117,443	0	117,443	67.00
68.00	06800 SPEECH PATHOLOGY	0	120,701	0	120,701	68.00
69.00	06900 ELECTROCARDIOLOGY		2,808,387	0	2,808,387	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		2,559,950	0	2,559,950	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		3,438,819	0	3,438,819	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		6,863,593	0	6,863,593	73.00
74.00	07400 RENAL DIALYSIS		517,077	0	517,077	74.00
76.00	03020 ACUPUNCTURE		0	0	0	76.00
76.01	03021 SLEEP LAB		201,558	0	201,558	76.01
76.03	03023 WOUND CARE		347,045	0	347,045	76.03
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC		0	0	0	88.00
90.00	09000 CLINIC		0	0	0	90.00
91.00	09100 EMERGENCY		4,494,934	0	4,494,934	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		1,478,898	0	1,478,898	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		0	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP. - RENTED		0	0	0	96.00
200.00	Subtotal (see instructions)		63,543,252	0	63,543,252	200.00
201.00	Less Observation Beds		1,478,898		1,478,898	201.00
202.00	Total (see instructions)		62,064,354	0	62,064,354	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet C
Part I
Date/Time Prepared:
9/30/2013 8:52 am

		Title XVIII			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	31,819,731		31,819,731		30.00
31.00	03100	INTENSIVE CARE UNIT	11,750,259		11,750,259		31.00
43.00	04300	NURSERY	2,254,432		2,254,432		43.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	32,802,149	31,248,613	64,050,762	0.107323	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,121,042	51,707	3,172,749	0.624413	52.00
53.00	05300	ANESTHESIOLOGY	10,808,442	5,316,083	16,124,525	0.021481	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,757,952	9,336,182	13,094,134	0.301755	54.00
54.01	05401	ULTRASOUND	1,572,792	3,008,704	4,581,496	0.098232	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	4,934,649	9,893,247	14,827,896	0.046022	56.00
57.00	05700	CT SCAN	7,380,161	18,249,360	25,629,521	0.028514	57.00
58.00	05800	MRI	683,659	3,405,435	4,089,094	0.068277	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	31,822,100	36,097,713	67,919,813	0.059060	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,262,527	1,928,860	4,191,387	0.301735	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	11,712,512	1,856,694	13,569,206	0.077027	65.00
66.00	06600	PHYSICAL THERAPY	3,389,186	3,149,411	6,538,597	0.203817	66.00
67.00	06700	OCCUPATIONAL THERAPY	612,925	223,668	836,593	0.140382	67.00
68.00	06800	SPEECH PATHOLOGY	468,055	71,228	539,283	0.223818	68.00
69.00	06900	ELECTROCARDIOLOGY	26,309,848	16,092,279	42,402,127	0.066232	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	15,326,066	8,297,476	23,623,542	0.108364	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,069,059	5,818,030	19,887,089	0.172917	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,303,273	14,996,732	42,300,005	0.162260	73.00
74.00	07400	RENAL DIALYSIS	1,938,409	21,173	1,959,582	0.263871	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	76.00
76.01	03021	SLEEP LAB	616	1,379,861	1,380,477	0.146006	76.01
76.03	03023	WOUND CARE	0	526	526	659.781369	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	9,095,529	30,239,824	39,335,353	0.114272	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,361,096	3,300,555	4,661,651	0.317248	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0.000000	96.00
200.00		Subtotal (see instructions)	256,556,469	203,983,361	460,539,830		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	256,556,469	203,983,361	460,539,830		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140184	Period: From 05/01/2012 To 04/30/2013	Worksheet C Part I Date/Time Prepared: 9/30/2013 8:52 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.107323		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.624413		52.00
53.00	05300 ANESTHESIOLOGY	0.021481		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.301755		54.00
54.01	05401 ULTRASOUND	0.098232		54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600 RADIOISOTOPE	0.046022		56.00
57.00	05700 CT SCAN	0.028514		57.00
58.00	05800 MRI	0.068277		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.059060		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.301735		62.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.077027		65.00
66.00	06600 PHYSICAL THERAPY	0.203817		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.140382		67.00
68.00	06800 SPEECH PATHOLOGY	0.223818		68.00
69.00	06900 ELECTROCARDIOLOGY	0.066232		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.108364		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.172917		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.162260		73.00
74.00	07400 RENAL DIALYSIS	0.263871		74.00
76.00	03020 ACUPUNCTURE	0.000000		76.00
76.01	03021 SLEEP LAB	0.146006		76.01
76.03	03023 WOUND CARE	659.781369		76.03
	OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC			88.00
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.114272		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.317248		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
96.00	09600 DURABLE MEDICAL EQUIP. - RENTED	0.000000		96.00
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: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet C
Part I
Date/Time Prepared:
9/30/2013 8:52 am

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS		11,574,829	0	0	30.00	
31.00	03100 INTENSIVE CARE UNIT		4,934,821	0	0	31.00	
43.00	04300 NURSERY		1,136,029	0	0	43.00	
44.00	04400 SKILLED NURSING FACILITY		0	0	0	44.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		6,874,133	0	0	50.00	
51.00	05100 RECOVERY ROOM		0	0	0	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM		1,981,106	0	0	52.00	
53.00	05300 ANESTHESIOLOGY		346,375	0	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		3,951,220	0	0	54.00	
54.01	05401 ULTRASOUND		450,050	0	0	54.01	
55.00	05500 RADIOLOGY-THERAPEUTIC		0	0	0	55.00	
56.00	05600 RADIOISOTOPE		682,415	0	0	56.00	
57.00	05700 CT SCAN		730,800	0	0	57.00	
58.00	05800 MRI		279,192	0	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00	
60.00	06000 LABORATORY		4,011,316	0	0	60.00	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		1,264,689	0	0	62.00	
64.00	06400 INTRAVENOUS THERAPY		0	0	0	64.00	
65.00	06500 RESPIRATORY THERAPY	0	1,045,197	0	0	65.00	
66.00	06600 PHYSICAL THERAPY	0	1,332,675	0	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	117,443	0	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0	120,701	0	0	68.00	
69.00	06900 ELECTROCARDIOLOGY		2,808,387	0	0	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY		0	0	0	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		2,559,950	0	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		3,438,819	0	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		6,863,593	0	0	73.00	
74.00	07400 RENAL DIALYSIS		517,077	0	0	74.00	
76.00	03020 ACUPUNCTURE		0	0	0	76.00	
76.01	03021 SLEEP LAB		201,558	0	0	76.01	
76.03	03023 WOUND CARE		347,045	0	0	76.03	
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC		0	0	0	88.00	
90.00	09000 CLINIC		0	0	0	90.00	
91.00	09100 EMERGENCY		4,494,934	0	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		1,478,898	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES		0	0	0	95.00	
96.00	09600 DURABLE MEDICAL EQUIP. - RENTED		0	0	0	96.00	
200.00	Subtotal (see instructions)		63,543,252	0	0	200.00	
201.00	Less Observation Beds		1,478,898	0	0	201.00	
202.00	Total (see instructions)		62,064,354	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet C
Part I
Date/Time Prepared:
9/30/2013 8:52 am

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	31,819,731		31,819,731		30.00
31.00	03100	INTENSIVE CARE UNIT	11,750,259		11,750,259		31.00
43.00	04300	NURSERY	2,254,432		2,254,432		43.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	32,802,149	31,248,613	64,050,762	0.107323	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,121,042	51,707	3,172,749	0.624413	52.00
53.00	05300	ANESTHESIOLOGY	10,808,442	5,316,083	16,124,525	0.021481	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,757,952	9,336,182	13,094,134	0.301755	54.00
54.01	05401	ULTRASOUND	1,572,792	3,008,704	4,581,496	0.098232	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	4,934,649	9,893,247	14,827,896	0.046022	56.00
57.00	05700	CT SCAN	7,380,161	18,249,360	25,629,521	0.028514	57.00
58.00	05800	MRI	683,659	3,405,435	4,089,094	0.068277	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	31,822,100	36,097,713	67,919,813	0.059060	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,262,527	1,928,860	4,191,387	0.301735	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	11,712,512	1,856,694	13,569,206	0.077027	65.00
66.00	06600	PHYSICAL THERAPY	3,389,186	3,149,411	6,538,597	0.203817	66.00
67.00	06700	OCCUPATIONAL THERAPY	612,925	223,668	836,593	0.140382	67.00
68.00	06800	SPEECH PATHOLOGY	468,055	71,228	539,283	0.223818	68.00
69.00	06900	ELECTROCARDIOLOGY	26,309,848	16,092,279	42,402,127	0.066232	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	15,326,066	8,297,476	23,623,542	0.108364	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,069,059	5,818,030	19,887,089	0.172917	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,303,273	14,996,732	42,300,005	0.162260	73.00
74.00	07400	RENAL DIALYSIS	1,938,409	21,173	1,959,582	0.263871	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	76.00
76.01	03021	SLEEP LAB	616	1,379,861	1,380,477	0.146006	76.01
76.03	03023	WOUND CARE	0	526	526	659.781369	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	9,095,529	30,239,824	39,335,353	0.114272	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,361,096	3,300,555	4,661,651	0.317248	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0.000000	96.00
200.00		Subtotal (see instructions)	256,556,469	203,983,361	460,539,830		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	256,556,469	203,983,361	460,539,830		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140184	Period: From 05/01/2012 To 04/30/2013	Worksheet C Part I Date/Time Prepared: 9/30/2013 8:52 am
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401 ULTRASOUND	0.000000		54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	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
74.00	07400 RENAL DIALYSIS	0.000000		74.00
76.00	03020 ACUPUNCTURE	0.000000		76.00
76.01	03021 SLEEP LAB	0.000000		76.01
76.03	03023 WOUND CARE	0.000000		76.03
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
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
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
96.00	09600 DURABLE MEDICAL EQUIP. - RENTED	0.000000		96.00
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: 140184	Period: From 05/01/2012 To 04/30/2013	Worksheet D Part I Date/Time Prepared: 9/30/2013 8:52 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,906,158	0	1,906,158	15,849	120.27	30.00
31.00	INTENSIVE CARE UNIT	663,930		663,930	3,050	217.68	31.00
43.00	NURSERY	117,867		117,867	1,628	72.40	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30-199)	2,687,955		2,687,955	20,527		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	7,474	898,898				
31.00	INTENSIVE CARE UNIT	1,847	402,055				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	0	0				
200.00	Total (lines 30-199)	9,321	1,300,953				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet D
Part II
Date/Time Prepared:
9/30/2013 8:52 am

Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,051,234	64,050,762	0.016413	15,578,770	255,694	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	257,645	3,172,749	0.081206	21,260	1,726	52.00
53.00	05300	ANESTHESIOLOGY	37,166	16,124,525	0.002305	3,053,155	7,038	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	386,589	13,094,134	0.029524	2,419,273	71,427	54.00
54.01	05401	ULTRASOUND	96,753	4,581,496	0.021118	997,796	21,071	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600	RADIOISOTOPE	45,861	14,827,896	0.003093	2,935,568	9,080	56.00
57.00	05700	CT SCAN	74,387	25,629,521	0.002902	4,771,798	13,848	57.00
58.00	05800	MRI	59,187	4,089,094	0.014474	348,281	5,041	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	308,840	67,919,813	0.004547	19,403,924	88,230	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	31,681	4,191,387	0.007559	1,502,725	11,359	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	83,796	13,569,206	0.006175	7,920,622	48,910	65.00
66.00	06600	PHYSICAL THERAPY	299,311	6,538,597	0.045776	2,516,791	115,209	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,577	836,593	0.011448	429,224	4,914	67.00
68.00	06800	SPEECH PATHOLOGY	6,565	539,283	0.012174	64,093	780	68.00
69.00	06900	ELECTROCARDIOLOGY	247,937	42,402,127	0.005847	14,330,175	83,789	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	76,369	23,623,542	0.003233	8,697,037	28,118	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	86,980	19,887,089	0.004374	7,430,712	32,502	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	218,990	42,300,005	0.005177	16,108,738	83,395	73.00
74.00	07400	RENAL DIALYSIS	22,391	1,959,582	0.011426	1,512,440	17,281	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03021	SLEEP LAB	100,877	1,380,477	0.073074	0	0	76.01
76.03	03023	WOUND CARE	117,724	526	223.809886	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	543,353	39,335,353	0.013813	5,895,943	81,441	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	243,546	4,661,651	0.052245	631,412	32,988	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50-199)	4,406,759	414,715,408		116,569,737	1,013,841	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140184	Period: From 05/01/2012 To 04/30/2013	Worksheet D Part III Date/Time Prepared: 9/30/2013 8:52 am
		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
43.00	04300	NURSERY	0	0	0	0	0 43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
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	15,849	0.00	7,474	0	0 30.00
31.00	03100	INTENSIVE CARE UNIT	3,050	0.00	1,847	0	0 31.00
43.00	04300	NURSERY	1,628	0.00	0	0	0 43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0	0 44.00
200.00		Total (lines 30-199)	20,527		9,321	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
31.00	03100	INTENSIVE CARE UNIT	0	0
43.00	04300	NURSERY	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0
200.00		Total (lines 30-199)	0	0

30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
200.00		Total (lines 30-199)	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet D
Part IV
Date/Time Prepared:
9/30/2013 8:52 am

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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03021	SLEEP LAB	0	0	0	0	76.01
76.03	03023	WOUND CARE	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
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
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	96.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet D
Part IV
Date/Time Prepared:
9/30/2013 8:52 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	64,050,762	0.000000	0.000000	15,578,770	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,172,749	0.000000	0.000000	21,260	52.00
53.00	05300	ANESTHESIOLOGY	0	16,124,525	0.000000	0.000000	3,053,155	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,094,134	0.000000	0.000000	2,419,273	54.00
54.01	05401	ULTRASOUND	0	4,581,496	0.000000	0.000000	997,796	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0	14,827,896	0.000000	0.000000	2,935,568	56.00
57.00	05700	CT SCAN	0	25,629,521	0.000000	0.000000	4,771,798	57.00
58.00	05800	MRI	0	4,089,094	0.000000	0.000000	348,281	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	67,919,813	0.000000	0.000000	19,403,924	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	4,191,387	0.000000	0.000000	1,502,725	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	13,569,206	0.000000	0.000000	7,920,622	65.00
66.00	06600	PHYSICAL THERAPY	0	6,538,597	0.000000	0.000000	2,516,791	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	836,593	0.000000	0.000000	429,224	67.00
68.00	06800	SPEECH PATHOLOGY	0	539,283	0.000000	0.000000	64,093	68.00
69.00	06900	ELECTROCARDIOLOGY	0	42,402,127	0.000000	0.000000	14,330,175	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	23,623,542	0.000000	0.000000	8,697,037	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	19,887,089	0.000000	0.000000	7,430,712	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	42,300,005	0.000000	0.000000	16,108,738	73.00
74.00	07400	RENAL DIALYSIS	0	1,959,582	0.000000	0.000000	1,512,440	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03021	SLEEP LAB	0	1,380,477	0.000000	0.000000	0	76.01
76.03	03023	WOUND CARE	0	526	0.000000	0.000000	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	39,335,353	0.000000	0.000000	5,895,943	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	4,661,651	0.000000	0.000000	631,412	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	0.000000	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	0	0	0.000000	0.000000	0	96.00
200.00		Total (lines 50-199)	0	414,715,408			116,569,737	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet D
Part IV
Date/Time Prepared:
9/30/2013 8:52 am

Cost Center Description			Title XVIII					Hospital	PPS
			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	5,416,947	3,809,789	0	0	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0	980,973	555,331	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,912,387	846,493	0	0	54.00	
54.01	05401	ULTRASOUND	0	859,612	422,104	0	0	54.01	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00	
56.00	05600	RADIOISOTOPE	0	2,179,762	1,110,309	0	0	56.00	
57.00	05700	CT SCAN	0	3,730,775	1,832,723	0	0	57.00	
58.00	05800	MRI	0	750,458	289,658	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00	06000	LABORATORY	0	722,053	415,012	0	0	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	667,049	393,812	0	0	62.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0	554,326	222,376	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	487	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	4,921,440	2,438,774	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,675,328	880,795	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,905,608	1,267,768	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,065,705	2,533,871	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00	
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00	
76.01	03021	SLEEP LAB	0	409,233	166,012	0	0	76.01	
76.03	03023	WOUND CARE	0	0	0	0	0	76.03	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00	
90.00	09000	CLINIC	0	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0	3,693,150	1,737,927	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	723,789	373,570	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00	
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	0	96.00	
200.00		Total (lines 50-199)	0	35,168,595	19,296,811	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet D
Part IV
Date/Time Prepared:
9/30/2013 8:52 am

Cost Center Description		Title XVIII				Hospital		PPS
		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	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00	
54.01	05401	ULTRASOUND	0	0	0	0	54.01	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00	
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00	
57.00	05700	CT SCAN	0	0	0	0	57.00	
58.00	05800	MRI	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00	
60.00	06000	LABORATORY	0	0	0	0	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00	
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00	
76.01	03021	SLEEP LAB	0	0	0	0	76.01	
76.03	03023	WOUND CARE	0	0	0	0	76.03	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00	
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	
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES					95.00	
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	96.00	
200.00		Total (Lines 50-199)	0	0	0	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140184	Period: From 05/01/2012 To 04/30/2013	Worksheet D Part V Date/Time Prepared: 9/30/2013 8:52 am
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)
		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	0.107323	5,416,947	3,809,789	0	0	50.00	
51.00 05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.624413	0	0	0	0	52.00	
53.00 05300 ANESTHESIOLOGY	0.021481	980,973	555,331	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.301755	1,912,387	846,493	0	0	54.00	
54.01 05401 ULTRASOUND	0.098232	859,612	422,104	0	0	54.01	
55.00 05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00	
56.00 05600 RADIO SOTOPE	0.046022	2,179,762	1,110,309	0	0	56.00	
57.00 05700 CT SCAN	0.028514	3,730,775	1,832,723	0	0	57.00	
58.00 05800 MRI	0.068277	750,458	289,658	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00	
60.00 06000 LABORATORY	0.059060	722,053	415,012	0	0	60.00	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.301735	667,049	393,812	0	0	62.00	
64.00 06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00	
65.00 06500 RESPIRATORY THERAPY	0.077027	554,326	222,376	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	0.203817	0	487	0	0	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0.140382	0	0	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0.223818	0	0	0	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	0.066232	4,921,440	2,438,774	0	0	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.108364	1,675,328	880,795	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.172917	1,905,608	1,267,768	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0.162260	4,065,705	2,533,871	0	0	73.00	
74.00 07400 RENAL DIALYSIS	0.263871	0	0	0	0	74.00	
76.00 03020 ACUPUNCTURE	0.000000	0	0	0	0	76.00	
76.01 03021 SLEEP LAB	0.146006	409,233	166,012	0	0	76.01	
76.03 03023 WOUND CARE	659.781369	0	0	0	0	76.03	
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00	
90.00 09000 CLINIC	0.000000	0	0	0	0	90.00	
91.00 09100 EMERGENCY	0.114272	3,693,150	1,737,927	0	0	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.317248	723,789	373,570	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS							
95.00 09500 AMBULANCE SERVICES	0.000000	0	0	0	0	95.00	
96.00 09600 DURABLE MEDICAL EQUIP. - RENTED	0.000000	0	0	0	0	96.00	
200.00		35,168,595	19,296,811	0	0	200.00	
201.00				0	0	201.00	
202.00		35,168,595	19,296,811	0	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140184	Period: From 05/01/2012 To 04/30/2013	Worksheet D Part V Date/Time Prepared: 9/30/2013 8:52 am
	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	581,363	408,878	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00 05300 ANESTHESIOLOGY	21,072	11,929	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	577,072	255,433	0	0		54.00
54.01 05401 ULTRASOUND	84,441	41,464	0	0		54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0		55.00
56.00 05600 RADIO SOTOP	100,317	51,099	0	0		56.00
57.00 05700 CT SCAN	106,379	52,258	0	0		57.00
58.00 05800 MRI	51,239	19,777	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00 06000 LABORATORY	42,644	24,511	0	0		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	201,272	118,827	0	0		62.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	42,698	17,129	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	99	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	325,957	161,525	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	181,545	95,446	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	329,512	219,219	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	659,701	411,146	0	0		73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0		74.00
76.00 03020 ACUPUNCTURE	0	0	0	0		76.00
76.01 03021 SLEEP LAB	59,750	24,239	0	0		76.01
76.03 03023 WOUND CARE	0	0	0	0		76.03
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0		88.00
90.00 09000 CLINIC	0	0	0	0		90.00
91.00 09100 EMERGENCY	422,024	198,596	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	229,621	118,514	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES			0			95.00
96.00 09600 DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0		96.00
200.00 Subtotal (see instructions)	4,016,607	2,230,089	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0			201.00
202.00 Net Charges (line 200 +/- line 201)	4,016,607	2,230,089	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140184	Period: From 05/01/2012 To 04/30/2013	Worksheet D-1 Date/Time Prepared: 9/30/2013 8:52 am
		Title XVIII	Hospital	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)		15,849	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		15,849	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)		13,824	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)		7,474	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)		11,574,829	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)		11,574,829	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		45,824,422	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		45,824,422	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.252591	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)		3,314.85	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)		11,574,829	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)		730.32	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,458,412	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)		5,458,412	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140184		Period: From 05/01/2012 To 04/30/2013		Worksheet D-1	
Date/Time Prepared: 9/30/2013 8:52 am		Title XVIII		Hospital		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)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	4,934,821	3,050	1,617.97	1,847	2,988,391		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)					12,734,301		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					21,181,104		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)					1,300,953		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,013,841		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					2,314,794		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					18,866,310		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)					2,025		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					730.32		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,478,898		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140184		Period: From 05/01/2012 To 04/30/2013		Worksheet D-1 Date/Time Prepared: 9/30/2013 8:52 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,906,158	11,574,829	0.164681	1,478,898	243,546	90.00
91.00	Nursing School cost	0	11,574,829	0.000000	1,478,898	0	91.00
92.00	Allied health cost	0	11,574,829	0.000000	1,478,898	0	92.00
93.00	All other Medical Education	0	11,574,829	0.000000	1,478,898	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140184	Period: From 05/01/2012 To 04/30/2013	Worksheet D-3 Date/Time Prepared: 9/30/2013 8:52 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		18,042,935		30.00
31.00	03100 INTENSIVE CARE UNIT		7,113,039		31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.107323	15,578,770	1,671,960	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.624413	21,260	13,275	52.00
53.00	05300 ANESTHESIOLOGY	0.021481	3,053,155	65,585	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.301755	2,419,273	730,028	54.00
54.01	05401 ULTRASOUND	0.098232	997,796	98,015	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0.046022	2,935,568	135,101	56.00
57.00	05700 CT SCAN	0.028514	4,771,798	136,063	57.00
58.00	05800 MRI	0.068277	348,281	23,780	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.059060	19,403,924	1,145,996	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.301735	1,502,725	453,425	62.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.077027	7,920,622	610,102	65.00
66.00	06600 PHYSICAL THERAPY	0.203817	2,516,791	512,965	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.140382	429,224	60,255	67.00
68.00	06800 SPEECH PATHOLOGY	0.223818	64,093	14,345	68.00
69.00	06900 ELECTROCARDIOLOGY	0.066232	14,330,175	949,116	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.108364	8,697,037	942,446	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.172917	7,430,712	1,284,896	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.162260	16,108,738	2,613,804	73.00
74.00	07400 RENAL DIALYSIS	0.263871	1,512,440	399,089	74.00
76.00	03020 ACUPUNCTURE	0.000000	0	0	76.00
76.01	03021 SLEEP LAB	0.146006	0	0	76.01
76.03	03023 WOUND CARE	659.781369	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.114272	5,895,943	673,741	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.317248	631,412	200,314	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
96.00	09600 DURABLE MEDICAL EQUIP. - RENTED	0.000000	0	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		116,569,737	12,734,301	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)		116,569,737		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140184	Period: From 05/01/2012 To 04/30/2013	Worksheet E Part A Date/Time Prepared: 9/30/2013 8:52 am
		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		14,090,464	1.00
2.00	Outlier payments for discharges. (see instructions)		718,943	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)		86.45	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)		6.63	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		27.08	31.00
32.00	Sum of lines 30 and 31		33.71	32.00
33.00	Allowable disproportionate share percentage (see instructions)		16.44	33.00
34.00	Disproportionate share adjustment (see instructions)		2,316,472	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	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0	46.00
47.00	Subtotal (see instructions)		17,125,879	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		16,242,871	48.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140184	Period: From 05/01/2012 To 04/30/2013	Worksheet E Part A Date/Time Prepared: 9/30/2013 8:52 am
		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)		17,125,879	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		1,259,581	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)		18,385,460	59.00
60.00	Primary payer payments		34,841	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		18,350,619	61.00
62.00	Deductibles billed to program beneficiaries		1,492,848	62.00
63.00	Coinsurance billed to program beneficiaries		41,190	63.00
64.00	Allowable bad debts (see instructions)		319,011	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		223,308	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		278,784	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		17,039,889	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)		-24,655	70.00
70.93	HVBP incentive payment (see instructions)		-6,987	70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		-80,934	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)		16,927,313	71.00
72.00	Interim payments		17,065,360	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)		-138,047	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		1,209,398	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: 140184		Period: From 05/01/2012 To 04/30/2013		Worksheet DSH	
		Title XVIII		Hospital		Date/Time Prepared: 9/30/2013 8:52 am	
		PPS					
		Original .mcrcx 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)	6.63	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	27.08	0.00			27.08	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	33.71	0.00			27.08	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	RRC				RRC	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	86.45	0.00			86.45	5.00
6.00	Disproportionate Share Payment Percentage (transfer to Worksheet E, Part A, line 33)	16.44	0.00			11.56	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	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	Yes				Yes	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")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	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)	4,853	0			4,853	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	0	0			0	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	3	0			3	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)	8	0			8	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)	5,010	0			5,010	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	18,502	0			18,502	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)	18,502	0			18,502	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	27.08	0.00			27.08	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140184		Period: From 05/01/2012 To 04/30/2013		Worksheet DSH	
		Title XVIII		Hospital		Date/Time Prepared: 9/30/2013 8:52 am	
		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	True	17.03		0.00	True	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False	29.00
30.00	Line 28 or 29 as applicable		17.03		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.		17.03		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")	True				True	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: 140184	Period: From 05/01/2012 To 04/30/2013	Worksheet DSH Date/Time Prepared: 9/30/2013 8:52 am
		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	11.56	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00	29.00
30.00	Line 28 or 29 as applicable	11.56	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.	11.56	31.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
9/30/2013 8:52 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01		
		0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00	14,090,464	0	5,499,248	8,591,216	1.00	
2.00	Outlier payments for discharges (see instructions)	2.00	718,943	0	0	0	2.00	
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00	
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00	
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	5.00	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00	
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	Amount from Worksheet E Part A, line 27 (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	7.00	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00	
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00	
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1644	0.1644	0.1644	0.1644	10.00	
11.00	Disproportionate share adjustment (see instructions)	34.00	2,316,472	0	904,076	1,412,396	11.00	
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00	
13.00	Subtotal (see instructions)	47.00	17,125,879	0	6,403,324	10,722,555	13.00	
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	48.00	16,242,871	0	6,359,794	9,883,077	14.00	
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49.00	17,125,879	0	6,403,324	10,722,555	15.00	
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50.00	1,259,581	0	487,902	771,679	16.00	
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00	
19.00	SUBTOTAL			0	6,891,226	11,494,234	19.00	
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00		
20.00	Capital DRG other than outlier	1.00	1,111,334	0	438,100	673,233	20.00	
21.00	Capital DRG outlier payments	2.00	148,247	0	49,802	98,444	21.00	
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	22.00	
23.00	Indirect medical education adjustment (line 20 times line 22)	6.00	0	0	0	0	23.00	
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	24.00	
25.00	Disproportionate share adjustment (line 20 times line 24)	11.00	0	0	0	0	25.00	
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	12.00	1,259,581	0	487,902	771,679	26.00	
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00		
27.00	Low volume adjustment factor				0.000000	0.000000	27.00	
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.96			0	0	28.00	
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.97				0	29.00	
100.00	Transfer low volume adjustments to W/S E Part A.		Y				100.00	

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
9/30/2013 8:52 am

Title XVII

Hospital

PPS

		Total (Col 2 through 4) 5.00		
1.00	DRG amounts other than outlier payments	14,090,464		1.00
2.00	Outlier payments for discharges (see instructions)	0		2.00
3.00	Operating outlier reconciliation	0		3.00
4.00	Managed care simulated payments	0		4.00
Indirect Medical Education Adjustment				
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)			5.00
6.00	IME payment adjustment (see instructions)	0		6.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
7.00	Amount from Worksheet E Part A, line 27 (see instructions)			7.00
8.00	IME adjustment (see instructions)	0		8.00
9.00	Total IME payment (sum of lines 6 and 8)	0		9.00
Disproportionate Share Adjustment				
10.00	Allowable disproportionate share percentage (see instructions)			10.00
11.00	Disproportionate share adjustment (see instructions)	2,316,472		11.00
Additional payment for high percentage of ESRD beneficiary discharges				
12.00	Total ESRD additional payment (see instructions)	0		12.00
13.00	Subtotal (see instructions)	17,125,879		13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	16,242,871		14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	17,125,879		15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	1,259,581		16.00
17.00	Special add-on payments for new technologies	0		17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	0		18.00
19.00	SUBTOTAL	18,385,460		19.00
		5.00		
20.00	Capital DRG other than outlier	1,111,333		20.00
21.00	Capital DRG outlier payments	148,246		21.00
22.00	Indirect medical education percentage (see instructions)			22.00
23.00	Indirect medical education adjustment (line 20 times line 22)	0		23.00
24.00	Allowable disproportionate share percentage (see instructions)			24.00
25.00	Disproportionate share adjustment (line 20 times line 24)	0		25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	1,259,581		26.00
		5.00		
27.00	Low volume adjustment factor			27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	0		28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	0		29.00
100.00	Transfer low volume adjustments to W/S E Part A.			100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140184	Period: From 05/01/2012 To 04/30/2013	Worksheet E Part B Date/Time Prepared: 9/30/2013 8:52 am
		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)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		4,016,607	2,230,089
3.00	PPS payments		3,538,385	1,840,579
4.00	Outlier payment (see instructions)		69,973	81,525
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.836	0.836
6.00	Line 2 times line 5		3,357,883	1,864,354
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	0.00
8.00	Transitional corridor payment (see instructions)		0	0
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	0
10.00	Organ acquisitions		0	0
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	0
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		5,530,462	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		1,220,430	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		4,310,032	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)		4,310,032	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		4,310,032	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)		291,167	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		203,817	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		277,628	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		4,513,849	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		-8,028	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)		4,505,821	40.00
41.00	Interim payments		4,775,275	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)		-269,454	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: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet E-1
Part I
Date/Time Prepared:
9/30/2013 8:52 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		17,065,360		4,775,275	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		17,065,360		4,775,275	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		138,047		269,454	6.02	
7.00	Total Medicare program liability (see instructions)		16,927,313		4,505,821	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: 140184
Component CCN: 14U184

Period:
From 05/01/2012
To 04/30/2013

Worksheet E-1
Part I
Date/Time Prepared:
9/30/2013 8:52 am

Title XVIII Swing Beds - SNF 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		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		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		0		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)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 140184
Component CCN: 14U184

Period:
From 05/01/2012
To 04/30/2013

Worksheet E-2
Date/Time Prepared:
9/30/2013 8:52 am

		Title XVIII		Swing Beds - SNF		PPS	
		Part A	Part B				
		1.00	2.00				
COMPUTATION OF NET COST OF COVERED SERVICES							
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0	0			1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)						2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)						3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)					0.00	4.00
5.00	Program days		0	0			5.00
6.00	Interns and residents not in approved teaching program (see instructions)					0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0				7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0			0	8.00
9.00	Primary payer payments (see instructions)		0			0	9.00
10.00	Subtotal (line 8 minus line 9)		0			0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0			0	11.00
12.00	Subtotal (line 10 minus line 11)		0			0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		0			0	13.00
14.00	80% of Part B costs (line 12 x 80%)					0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0			0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0			0	16.00
17.00	Reimbursable bad debts (see instructions)		0			0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0			0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)		0			0	19.00
20.00	Interim payments		0			0	20.00
21.00	Tentative settlement (for contractor use only)		0			0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)		0			0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2		0			0	23.00

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

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet G

Date/Time Prepared:
9/30/2013 8:52 am

		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	-546,852	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	20,287,987	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,278,832	0	0	0	6.00
7.00	Inventory	2,741,618	0	0	0	7.00
8.00	Prepaid expenses	745,042	0	0	0	8.00
9.00	Other current assets	-1,002,209	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)	19,946,754	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,393,860	0	0	0	12.00
13.00	Land improvements	579,177	0	0	0	13.00
14.00	Accumulated depreciation	-312,236	0	0	0	14.00
15.00	Buildings	46,957,319	0	0	0	15.00
16.00	Accumulated depreciation	-8,928,944	0	0	0	16.00
17.00	Leasehold improvements	3,058,971	0	0	0	17.00
18.00	Accumulated depreciation	-1,255,630	0	0	0	18.00
19.00	Fixed equipment	2,182,183	0	0	0	19.00
20.00	Accumulated depreciation	-1,124,822	0	0	0	20.00
21.00	Automobiles and trucks	32,883	0	0	0	21.00
22.00	Accumulated depreciation	-31,265	0	0	0	22.00
23.00	Major movable equipment	18,350,916	0	0	0	23.00
24.00	Accumulated depreciation	-9,374,719	0	0	0	24.00
25.00	Minor equipment depreciable	6,292,149	0	0	0	25.00
26.00	Accumulated depreciation	-3,954,116	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	53,865,726	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	3,805,440	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,805,440	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	77,617,920	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	4,171,058	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,624,821	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	25,008	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	-196,384,026	0	0	0	43.00
44.00	Other current liabilities	1,427,520	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-189,135,619	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	14,590	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	14,590	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-189,121,029	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	266,738,949				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)	266,738,949	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	77,617,920	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet G-1

Date/Time Prepared:
9/30/2013 8:52 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		232,762,777		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		33,976,167			2.00
3.00	Total (sum of line 1 and line 2)		266,738,944		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)		266,738,944		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		266,738,944		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			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: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet G-2
Parts I & II
Date/Time Prepared:
9/30/2013 8:52 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	34,074,163		34,074,163	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	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)	34,074,163		34,074,163	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	11,750,259		11,750,259	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)	11,750,259		11,750,259	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	45,824,422		45,824,422	17.00
18.00	Ancillary services	214,679,803		214,679,803	18.00
19.00	Outpatient services	0	203,983,361	203,983,361	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	0	0	0	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)	260,504,225	203,983,361	464,487,586	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		80,568,425		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)		80,568,425		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet G-3

Date/Time Prepared:
9/30/2013 8:52 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	464,487,586	1.00
2.00	Less contractual allowances and discounts on patients' accounts	351,084,265	2.00
3.00	Net patient revenues (line 1 minus line 2)	113,403,321	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	80,568,425	4.00
5.00	Net income from service to patients (line 3 minus line 4)	32,834,896	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	1,141,271	24.00
25.00	Total other income (sum of lines 6-24)	1,141,271	25.00
26.00	Total (line 5 plus line 25)	33,976,167	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	33,976,167	29.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B

Provider CCN: 140184

Period:
From 05/01/2012
To 04/30/2013

Worksheet 1-5

Date/Time Prepared:
9/30/2013 8:52 am

		1.00	
1.00	Total expenses related to care of program beneficiaries (see instructions)	0	1.00
2.00	Total payment (from Worksheet 1-4, column 6, line 11)	0	2.00
3.00	Deductibles billed to Medicare (Part B) patients	0	3.00
4.00	Coinsurance billed to Medicare (Part B) patients	0	4.00
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	0	5.00
6.00			6.00
7.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (sum of lines 3 and 4 less line 5)	0	8.00
9.00	Program payment (line 2 less line 3, times 80 percent)	0	9.00
10.00	Unrecovered from Medicare (Part B) patients (Line 1 minus the sum of lines 8 and 9. If negative, enter zero and do not complete line 11.)	0	10.00
11.00	Reimbursable bad debts (lesser of line 10 or line 5) (transfer to Worksheet E, Part B, line 33)	0	11.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140184	Period: From 05/01/2012 To 04/30/2013	Worksheet L Parts I-III Date/Time Prepared: 9/30/2013 8:52 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,111,334	1.00
2.00	Capital DRG outlier payments		148,247	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		46.23	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)		1,259,581	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