

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140011	Period: From 04/01/2013 To 03/31/2014	Worksheet S Parts I-III Date/Time Prepared: 8/26/2014 2:16 pm
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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: 8/26/2014 Time: 2:16 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HERRIN HOSPITAL ( 140011 ) for the cost reporting period beginning 04/01/2013 and ending 03/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	727,920	83,660	41,214	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	193,112	629		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	921,032	84,289	41,214	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140011		Period: From 04/01/2013 To 03/31/2014		Worksheet S-2 Part I Date/Time Prepared: 8/26/2014 2:09 pm							
1.00		2.00		3.00		4.00							
Hospital and Hospital Health Care Complex Address:													
1.00	Street: 201 S. 14TH STREET			PO Box:						1.00			
2.00	City: HERRIN			State: IL		Zip Code: 62948		County: WILLIAMSON		2.00			
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)					
1.00		2.00		3.00	4.00	5.00	6.00	7.00	8.00				
Hospital and Hospital-Based Component Identification:													
3.00	Hospital		HERRIN HOSPITAL	140011	99914	1	07/01/1966	N	P	0	3.00		
4.00	Subprovider - IPF										4.00		
5.00	Subprovider - IRF		HERRIN HOSPITAL ACUTE REHAB	14T011	99914	5	04/01/1998	N	P	0	5.00		
6.00	Subprovider - (Other)										6.00		
7.00	Swing Beds - SNF										7.00		
8.00	Swing Beds - NF										8.00		
9.00	Hospital-Based SNF										9.00		
10.00	Hospital-Based NF										10.00		
11.00	Hospital-Based OLTC										11.00		
12.00	Hospital-Based HHA										12.00		
13.00	Separately Certified ASC										13.00		
14.00	Hospital-Based Hospice										14.00		
15.00	Hospital-Based Health Clinic - RHC										15.00		
16.00	Hospital-Based Health Clinic - FQHC										16.00		
17.00	Hospital-Based (CMHC) I										17.00		
18.00	Renal Dialysis										18.00		
19.00	Other										19.00		
							From:	To:					
							1.00	2.00					
20.00	Cost Reporting Period (mm/dd/yyyy)						04/01/2013	03/31/2014		20.00			
21.00	Type of Control (see instructions)						2		21.00				
Inpatient PPS Information													
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						Y	N		22.00			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N	Y		22.01			
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						1	N		23.00			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days						
		1.00	2.00	3.00	4.00	5.00	6.00						
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.						1,822	107	0	0	6	145	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.						887	164	0	0	0		25.00
							Urban/Rural S	Date of Geogr					
							1.00	2.00					
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						2				26.00		
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						2				27.00		
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0				35.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140011	Period: From 04/01/2013 To 03/31/2014	Worksheet S-2 Part I Date/Time Prepared: 8/26/2014 2:09 pm			
		Beginning: 1.00	Ending: 2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	1				37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.	04/01/2013	03/31/2014			38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00	
		V	XVIII	XIX			
		1.00	2.00	3.00			
<b>Prospective Payment System (PPS)-Capital</b>							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00	
<b>Teaching Hospitals</b>							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					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	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10	

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	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
	1.00	2.00	3.00	4.00		
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.		0.00	0.00	61.20	
				1.00		
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
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	
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)			N	63.00	
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	3.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010. Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00

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

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		V 1.00	XIX 2.00			
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)				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 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				109.00	
				1.00	2.00	
					3.00	
<b>Miscellaneous Cost Reporting Information</b>						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00	
		Premiums 1.00	Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	2,568,477	0	0		
			1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02	
119.00	DO NOT USE THIS LINE				119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N		Y	120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00	
<b>Transplant Center Information</b>						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			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	
<b>All Providers</b>						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		14H124	140.00	

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1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: SOUTHERN ILLINOIS HEALTHCARE	Contractor's Name: NGS		Contractor's Number: 06101			
142.00	Street: 1239 E. MAIN STREET	PO Box: 3988					
143.00	City: CARBONDALE	State: IL		Zip Code: 62902-3988			
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?				Y	144.00	
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.				N	145.00	
				1.00			
				2.00			
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N	146.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N	149.00	
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
				1.00			
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						
				1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.				Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0	
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)				1.00	169.00	
				Beginning		Ending	
				1.00		2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				10/01/2012	12/31/2012	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140011	Period: From 04/01/2013 To 03/31/2014	Worksheet S-2 Part II Date/Time Prepared: 8/26/2014 2:09 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			Y	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	07/23/2014	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet S-2  
Part II  
Date/Time Prepared:  
8/26/2014 2:09 pm

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			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.			Y	27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			Y	35.00
				Y/N	Date
				1.00	2.00
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LUANNE		WARREN	41.00
42.00	Enter the employer/company name of the cost report preparer.	SOUTHERN I L HOSPITAL SERVICES			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	618-457-5200, EXT 67202		LUANNE.WARREN@SIH.NET	43.00

		Part B		
		Date		
		4.00		
<b>PS&amp;R Data</b>				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	07/23/2014		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HFS Supplemental Information		Provider CCN: 140011	Period: From 04/01/2013 To 03/31/2014	Worksheet S-2 Part IX Date/Time Prepared: 8/26/2014 2:09 pm
		Title V 1.00	Title XIX 2.00	
<b>TITLES V AND/OR XIX FOLLOWING MEDICARE</b>				
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 1.00	Outpatient 2.00	
<b>CRITICAL ACCESS HOSPITALS</b>				
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 1.00	Title XIX 2.00	
<b>RCE DISALLOWANCE</b>				
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
<b>PASS THROUGH COST</b>				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet S-3  
Part I  
Date/Time Prepared:  
8/26/2014 2:09 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	77	28,105	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		77	28,105	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		85	31,025	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	29	10,585		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		114				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet S-3  
Part I  
Date/Time Prepared:  
8/26/2014 2:09 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	11,222	1,686	16,325			1.00
2.00 HMO and other (see instructions)	601	151				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	149	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	11,222	1,686	16,325			7.00
8.00 INTENSIVE CARE UNIT	1,212	243	2,073			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)	12,434	1,929	18,398	0.00	682.05	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	5,046	1,051	7,105	0.00	52.22	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	734.27	27.00
28.00 Observation Bed Days		421	2,660			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet S-3  
Part I  
Date/Time Prepared:  
8/26/2014 2:09 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	3,088	605	4,968	1.00
2.00 HMO and other (see instructions)				133			2.00
3.00 HMO IPF Subprovider							3.00
4.00 HMO IRF Subprovider							4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0		3,088	605	4,968	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF	0.00	0		413	58	570	17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet S-3  
Part II  
Date/Time Prepared:  
8/26/2014 2:09 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	35,462,161	0	35,462,161	1,490,703.68	23.79
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)		2,698,812	-212,825	2,485,987	108,614.49	22.89
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract labor (see instructions)		732,669	0	732,669	12,498.83	58.62
12.00	Contract management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		265,868	0	265,868	1,863.00	142.71
14.00	Home office salaries & wage-related costs		7,883,629	0	7,883,629	187,980.43	41.94
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
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		9,684,432	0	9,684,432		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		730,084	0	730,084		
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		
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits Department	4.00	254,470	0	254,470	9,639.13	26.40
27.00	Administrative & General	5.00	2,700,622	0	2,700,622	121,523.46	22.22
28.00	Administrative & General under contract (see inst.)		151,474	0	151,474	608.85	248.79
29.00	Maintenance & Repairs	6.00	566,547	0	566,547	26,995.90	20.99
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00
31.00	Laundry & Linen Service	8.00	37,596	0	37,596	2,853.53	13.18
32.00	Housekeeping	9.00	865,410	0	865,410	70,469.32	12.28
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	964,666	-645,196	319,470	21,968.01	14.54
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	645,196	645,196	44,360.51	14.54
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	1,105,646	0	1,105,646	28,876.75	38.29
39.00	Central Services and Supply	14.00	180,266	0	180,266	13,102.98	13.76
40.00	Pharmacy	15.00	0	0	0	0.00	0.00
41.00	Medical Records & Medical Records Library	16.00	381,772	0	381,772	23,418.70	16.30

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet S-3  
Part II  
Date/Time Prepared:  
8/26/2014 2:09 pm

		Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
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: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet S-3  
Part III  
Date/Time Prepared:  
8/26/2014 2:09 pm

	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	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	35,613,635	0	35,613,635	1,491,312.53	23.88	1.00
2.00	Excluded area salaries (see instructions)	2,698,812	-212,825	2,485,987	108,614.49	22.89	2.00
3.00	Subtotal salaries (line 1 minus line 2)	32,914,823	212,825	33,127,648	1,382,698.04	23.96	3.00
4.00	Subtotal other wages & related costs (see inst.)	8,882,166	0	8,882,166	202,342.26	43.90	4.00
5.00	Subtotal wage-related costs (see inst.)	9,684,432	0	9,684,432	0.00	29.23	5.00
6.00	Total (sum of lines 3 thru 5)	51,481,421	212,825	51,694,246	1,585,040.30	32.61	6.00
7.00	Total overhead cost (see instructions)	7,208,469	0	7,208,469	363,817.14	19.81	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140011	Period: From 04/01/2013 To 03/31/2014	Worksheet S-3 Part IV Date/Time Prepared: 8/26/2014 2:09 pm
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions			630,568 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
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration Fees			1,546 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)			5,862,942 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			29,519 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			18,895 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)			125,460 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			413,019 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			434,775 16.00
<b>TAXES</b>				
17.00	FICA-Employers Portion Only			2,631,601 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			66,908 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			93,173 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			106,110 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			10,414,516 24.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet S-3  
Part V  
Date/Time Prepared:  
8/26/2014 2:09 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
<b>PART V - Contract Labor and Benefit Cost</b>				
<b>Hospital and Hospital-Based Component Identification:</b>				
1.00	Total facility's contract labor and benefit cost	523,311	9,684,432	1.00
2.00	Hospital	523,311	9,684,432	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 140011	Period: From 04/01/2013 To 03/31/2014	Worksheet S-10 Date/Time Prepared: 8/26/2014 2:09 pm
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				1.00		
<b>Uncompensated and indigent care cost computation</b>						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.235976	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			6,130,758	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			89,102	5.00	
6.00	Medicaid charges			73,114,339	6.00	
7.00	Medicaid cost (line 1 times line 6)			17,253,229	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)			11,033,369	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone SCHIP			0	9.00	
10.00	Stand-alone SCHIP charges			0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)			0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00	
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00	
Uncompensated care (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations			17,002	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			11,033,369	19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility			12,467,740	1,700,286	14,168,026
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)			2,942,087	401,227	3,343,314
22.00	Partial payment by patients approved for charity care			0	0	0
23.00	Cost of charity care (line 21 minus line 22)			2,942,087	401,227	3,343,314
				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
26.00	Total bad debt expense for the entire hospital complex (see instructions)					14,630,508
27.00	Medicare bad debts for the entire hospital complex (see instructions)					839,768
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)					13,790,740
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)					3,254,284
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)					6,597,598
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)					17,630,967

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet A  
Date/Time Prepared:  
8/26/2014 2:09 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		3,437,483	3,437,483	253,230	3,690,713	1.00
2.00	00200		2,523,996	2,523,996	94,040	2,618,036	2.00
4.00	00400		12,833,671	13,088,141	0	13,088,141	4.00
5.01	00550	254,470	0	0	0	0	5.01
5.02	00560	0	78,309	78,309	0	78,309	5.02
5.03	00580	722,900	61,291	784,191	0	784,191	5.03
5.04	00590	1,977,722	6,768,021	8,745,743	-15,743	8,730,000	5.04
6.00	00600	566,547	1,290,381	1,856,928	0	1,856,928	6.00
8.00	00800	37,596	235,193	272,789	0	272,789	8.00
9.00	00900	865,410	267,080	1,132,490	0	1,132,490	9.00
10.00	01000	964,666	667,775	1,632,441	-1,091,824	540,617	10.00
11.00	01100	0	0	0	1,091,824	1,091,824	11.00
13.00	01300	1,105,646	86,473	1,192,119	0	1,192,119	13.00
14.00	01400	180,266	54,683	234,949	-2,152	232,797	14.00
16.00	01600	381,772	23,974	405,746	0	405,746	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	882,108	882,108	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	6,586,176	4,580,310	11,166,486	-2,646	11,163,840	30.00
31.00	03100	1,497,709	479,367	1,977,076	-3,367	1,973,709	31.00
41.00	04100	2,485,987	1,793,110	4,279,097	-1,261	4,277,836	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	3,167,545	10,592,582	13,760,127	-7,981,055	5,779,072	50.00
51.00	05100	327,681	63,440	391,121	0	391,121	51.00
53.00	05300	33,734	1,012,907	1,046,641	-933,492	113,149	53.00
54.00	05400	2,200,514	556,241	2,756,755	-116,185	2,640,570	54.00
56.00	05600	286,324	1,324,995	1,611,319	24,299	1,635,618	56.00
57.00	05700	406,993	441,262	848,255	-5,063	843,192	57.00
58.00	05800	239,515	216,628	456,143	-31,044	425,099	58.00
60.00	06000	1,539,412	3,244,068	4,783,480	411,058	5,194,538	60.00
65.00	06500	1,112,480	366,529	1,479,009	-83,359	1,395,650	65.00
66.00	06600	2,563,883	504,226	3,068,109	-304	3,067,805	66.00
69.00	06900	584,081	335,890	919,971	-69,272	850,699	69.00
71.00	07100	0	0	0	4,658,576	4,658,576	71.00
72.00	07200	0	0	0	3,566,481	3,566,481	72.00
73.00	07300	1,852,086	3,668,575	5,520,661	186,727	5,707,388	73.00
76.97	07697	390,241	28,262	418,503	0	418,503	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	167,839	404,973	572,812	-18,655	554,157	90.00
91.00	09100	2,750,141	2,889,226	5,639,367	-6,659	5,632,708	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300		2,265,347	2,265,347	-347,270	1,918,077	113.00
118.00		35,249,336	63,096,268	98,345,604	458,992	98,804,596	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	107,091	107,091	0	107,091	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	212,825	246,167	458,992	-458,992	0	192.02
200.00		35,462,161	63,449,526	98,911,687	0	98,911,687	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet A  
Date/Time Prepared:  
8/26/2014 2:09 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	46,302	3,737,015	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,347,269	4,965,305	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	832,255	13,920,396	4.00
5.01	00550	DATA PROCESSING	3,960,445	3,960,445	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-5,010	73,299	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,273,464	3,057,655	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	1,208,261	9,938,261	5.04
6.00	00600	MAINTENANCE & REPAIRS	-199	1,856,729	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	272,789	8.00
9.00	00900	HOUSEKEEPING	0	1,132,490	9.00
10.00	01000	DIETARY	0	540,617	10.00
11.00	01100	CAFETERIA	-386,292	705,532	11.00
13.00	01300	NURSING ADMINISTRATION	-126	1,191,993	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	232,797	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-55,703	350,043	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-882,108	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-2,244,255	8,919,585	30.00
31.00	03100	INTENSIVE CARE UNIT	2,074	1,975,783	31.00
41.00	04100	SUBPROVIDER - I RF	-1,274,643	3,003,193	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-73,581	5,705,491	50.00
51.00	05100	RECOVERY ROOM	0	391,121	51.00
53.00	05300	ANESTHESIOLOGY	0	113,149	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-64,267	2,576,303	54.00
56.00	05600	RADIOISOTOPE	0	1,635,618	56.00
57.00	05700	CT SCAN	0	843,192	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	425,099	58.00
60.00	06000	LABORATORY	-44,132	5,150,406	60.00
65.00	06500	RESPIRATORY THERAPY	-6,100	1,389,550	65.00
66.00	06600	PHYSICAL THERAPY	-21,137	3,046,668	66.00
69.00	06900	ELECTROCARDIOLOGY	-134,247	716,452	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,658,576	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,566,481	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,707,388	73.00
76.97	07697	CARDIAC REHABILITATION	-3,641	414,862	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	-7,628	546,529	90.00
91.00	09100	EMERGENCY	-1,662,346	3,970,362	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	-1,918,077	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,886,578	100,691,174	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-15,429	91,662	192.00
192.01	19201	VACANT SPACE	0	0	192.01
192.02	19202	REFERENCE LAB	0	0	192.02
200.00		TOTAL (SUM OF LINES 118-199)	1,871,149	100,782,836	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet Non-CMS W  
Date/Time Prepared:  
8/26/2014 2:09 pm

Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
	1.00	2.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00 CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00 EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.01 DATA PROCESSING	00550		5.01
5.02 PURCHASING RECEIVING AND STORES	00560		5.02
5.03 CASHIERING/ACCOUNTS RECEIVABLE	00580		5.03
5.04 OTHER ADMINISTRATIVE AND GENERAL	00590		5.04
6.00 MAINTENANCE & REPAIRS	00600		6.00
8.00 LAUNDRY & LINEN SERVICE	00800		8.00
9.00 HOUSEKEEPING	00900		9.00
10.00 DIETARY	01000		10.00
11.00 CAFETERIA	01100		11.00
13.00 NURSING ADMINISTRATION	01300		13.00
14.00 CENTRAL SERVICES & SUPPLY	01400		14.00
16.00 MEDICAL RECORDS & LIBRARY	01600		16.00
17.00 SOCIAL SERVICE	01700		17.00
19.00 NONPHYSICIAN ANESTHETISTS	01900		19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00 ADULTS & PEDIATRICS	03000		30.00
31.00 INTENSIVE CARE UNIT	03100		31.00
41.00 SUBPROVIDER - IRF	04100		41.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 OPERATING ROOM	05000		50.00
51.00 RECOVERY ROOM	05100		51.00
53.00 ANESTHESIOLOGY	05300		53.00
54.00 RADIOLOGY-DIAGNOSTIC	05400		54.00
56.00 RADIOISOTOPE	05600		56.00
57.00 CT SCAN	05700		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
60.00 LABORATORY	06000		60.00
65.00 RESPIRATORY THERAPY	06500		65.00
66.00 PHYSICAL THERAPY	06600		66.00
69.00 ELECTROCARDIOLOGY	06900		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00 DRUGS CHARGED TO PATIENTS	07300		73.00
76.97 CARDIAC REHABILITATION	07697	CARDIAC REHABILITATION	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00 CLINIC	09000		90.00
91.00 EMERGENCY	09100		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00 INTEREST EXPENSE	11300		113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)			118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00 PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.01 VACANT SPACE	19201		192.01
192.02 REFERENCE LAB	19202		192.02
200.00 TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet A-6

Date/Time Prepared:  
8/26/2014 2:09 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - DIETARY RECLASS</b>					
1.00	CAFETERIA	11.00	645,196	446,628	1.00
	TOTALS		645,196	446,628	
<b>B - MEDICAL SUPPLY RECLASS</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	8,225,057	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
17.00		0.00	0	0	17.00
	TOTALS		0	8,225,057	
<b>C - CRNA RECLASS</b>					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	882,108	1.00
	TOTALS		0	882,108	
<b>D - INTEREST RECLASS</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	253,230	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	94,040	2.00
	TOTALS		0	347,270	
<b>E - BARIATRIC MED DIRECTOR RECLASS</b>					
1.00	OPERATING ROOM	50.00	0	15,600	1.00
	TOTALS		0	15,600	
<b>F - IMPLANTABLE DEVICE RECLASS</b>					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,566,481	1.00
	TOTALS		0	3,566,481	
<b>G - RADIOLOGY SCHEDULER RECLASS</b>					
1.00	CT SCAN	57.00	45,649	0	1.00
2.00	RADIOISOTOPE	56.00	24,639	0	2.00
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	10,963	0	3.00
	TOTALS		81,251	0	
<b>H - CONTRAST DRUG RECLASS</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	187,482	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	TOTALS		0	187,482	
<b>I - REFERENCE LAB RECLASS</b>					
1.00	LABORATORY	60.00	212,825	246,167	1.00
	TOTALS		212,825	246,167	
500.00	Grand Total: Increases		939,272	13,916,793	500.00

RECLASSIFICATIONS

Provider CCN: 140011

Period: From 04/01/2013 To 03/31/2014

Worksheet A-6

Date/Time Prepared: 8/26/2014 2:09 pm

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
<b>A - DIETARY RECLASS</b>							
1.00	DIETARY	10.00	645,196	446,628	0		1.00
	TOTALS		645,196	446,628			
<b>B - MEDICAL SUPPLY RECLASS</b>							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	143	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	2,646	0		2.00
3.00	SUBPROVIDER - IRF	41.00	0	1,261	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	3,367	0		4.00
5.00	OPERATING ROOM	50.00	0	7,996,655	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,152	0		6.00
7.00	EMERGENCY	91.00	0	6,659	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	51,384	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	9,229	0		9.00
10.00	RADIOISOTOPE	56.00	0	340	0		10.00
11.00	CT SCAN	57.00	0	21	0		11.00
12.00	LABORATORY	60.00	0	47,934	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	83,359	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	304	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	193	0		15.00
16.00	CLINIC	90.00	0	18,655	0		16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	0	755	0		17.00
	TOTALS		0	8,225,057			
<b>C - CRNA RECLASS</b>							
1.00	ANESTHESIOLOGY	53.00	0	882,108	0		1.00
	TOTALS		0	882,108			
<b>D - INTEREST RECLASS</b>							
1.00	INTEREST EXPENSE	113.00	0	347,270	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	347,270			
<b>E - BARIATRIC MED DIRECTOR RECLASS</b>							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	15,600	0		1.00
	TOTALS		0	15,600			
<b>F - IMPLANTABLE DEVICE RECLASS</b>							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,566,481	0		1.00
	TOTALS		0	3,566,481			
<b>G - RADIOLOGY SCHEDULER RECLASS</b>							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	81,251	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		81,251	0	0		
<b>H - CONTRAST DRUG RECLASS</b>							
1.00	ELECTROCARDIOLOGY	69.00	0	69,079	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	25,705	0		2.00
3.00	CT SCAN	57.00	0	50,691	0		3.00
4.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	42,007	0		4.00
	TOTALS		0	187,482			
<b>I - REFERENCE LAB RECLASS</b>							
1.00	REFERENCE LAB	192.02	212,825	246,167	0		1.00
	TOTALS		212,825	246,167			
500.00	Grand Total: Decreases		939,272	13,916,793			500.00

RECLASSIFICATIONS

Provider CCN: 140011

Period: From 04/01/2013 To 03/31/2014

Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 8/26/2014 2:09 pm

Increases			Decreases			
Cost Center	Line #	Salary	Cost Center	Line #	Salary	
2.00	3.00	4.00	6.00	7.00	8.00	
<b>A - DIETARY RECLASS</b>						
1.00	CAFETERIA	11.00	645,196	DIETARY	10.00	645,196
	TOTALS		645,196	TOTALS		645,196
<b>B - MEDICAL SUPPLY RECLASS</b>						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		OTHER ADMINISTRATIVE AND GENERAL	5.04	
2.00		0.00		ADULTS & PEDIATRICS	30.00	
3.00		0.00		SUBPROVIDER - IRF	41.00	
4.00		0.00		INTENSIVE CARE UNIT	31.00	
5.00		0.00		OPERATING ROOM	50.00	
6.00		0.00		CENTRAL SERVICES & SUPPLY	14.00	
7.00		0.00		EMERGENCY	91.00	
8.00		0.00		ANESTHESIOLOGY	53.00	
9.00		0.00		RADIOLOGY-DIAGNOSTIC	54.00	
10.00		0.00		RADIOISOTOPE	56.00	
11.00		0.00		CT SCAN	57.00	
12.00		0.00		LABORATORY	60.00	
13.00		0.00		RESPIRATORY THERAPY	65.00	
14.00		0.00		PHYSICAL THERAPY	66.00	
15.00		0.00		ELECTROCARDIOLOGY	69.00	
16.00		0.00		CLINIC	90.00	
17.00		0.00		DRUGS CHARGED TO PATIENTS	73.00	
	TOTALS			TOTALS		
<b>C - CRNA RECLASS</b>						
1.00	NONPHYSICIAN ANESTHETISTS	19.00		ANESTHESIOLOGY	53.00	
	TOTALS			TOTALS		
<b>D - INTEREST RECLASS</b>						
1.00	CAP REL COSTS-BLDG & FIXT	1.00		INTEREST EXPENSE	113.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00			0.00	
	TOTALS			TOTALS		
<b>E - BARIATRIC MED DIRECTOR RECLASS</b>						
1.00	OPERATING ROOM	50.00		OTHER ADMINISTRATIVE AND GENERAL	5.04	
	TOTALS			TOTALS		
<b>F - IMPLANTABLE DEVICE RECLASS</b>						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	
	TOTALS			TOTALS		
<b>G - RADIOLOGY SCHEDULER RECLASS</b>						
1.00	CT SCAN	57.00	45,649	RADIOLOGY-DIAGNOSTIC	54.00	81,251
2.00	RADIOISOTOPE	56.00	24,639		0.00	
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	10,963		0.00	
	TOTALS		81,251	TOTALS		81,251
<b>H - CONTRAST DRUG RECLASS</b>						
1.00	DRUGS CHARGED TO PATIENTS	73.00		ELECTROCARDIOLOGY	69.00	
2.00		0.00		RADIOLOGY-DIAGNOSTIC	54.00	
3.00		0.00		CT SCAN	57.00	
4.00		0.00		MAGNETIC RESONANCE IMAGING (MRI)	58.00	
	TOTALS			TOTALS		
<b>I - REFERENCE LAB RECLASS</b>						
1.00	LABORATORY	60.00	212,825	REFERENCE LAB	192.02	212,825
	TOTALS		212,825	TOTALS		212,825
500.00	Grand Total: Increases		939,272	Grand Total: Decreases		939,272

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet A-7  
Part I  
Date/Time Prepared:  
8/26/2014 2:09 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	3,696,434	85,669	0	85,669	0 1.00
2.00	Land Improvements	4,242,320	9,842	0	9,842	47,733 2.00
3.00	Buildings and Fixtures	36,938,810	1,063,026	0	1,063,026	625,126 3.00
4.00	Building Improvements	28,802,058	1,804,438	0	1,804,438	1,518,067 4.00
5.00	Fixed Equipment	0	0	0	0	0 5.00
6.00	Movable Equipment	22,804,040	2,553,004	0	2,553,004	1,220,708 6.00
7.00	HIT designated Assets	2,175,149	0	0	0	0 7.00
8.00	Subtotal (sum of lines 1-7)	98,658,811	5,515,979	0	5,515,979	3,411,634 8.00
9.00	Reconciling Items	0	0	0	0	0 9.00
10.00	Total (line 8 minus line 9)	98,658,811	5,515,979	0	5,515,979	3,411,634 10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	3,782,103	0			1.00
2.00	Land Improvements	4,204,429	0			2.00
3.00	Buildings and Fixtures	37,376,710	0			3.00
4.00	Building Improvements	29,088,429	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	24,136,336	0			6.00
7.00	HIT designated Assets	2,175,149	0			7.00
8.00	Subtotal (sum of lines 1-7)	100,763,156	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	100,763,156	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet A-7  
Part II  
Date/Time Prepared:  
8/26/2014 2:09 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	3,437,483	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,523,996	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,961,479	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	3,437,483				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,523,996				2.00
3.00	Total (sum of lines 1-2)	0	5,961,479				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet A-7  
Part III  
Date/Time Prepared:  
8/26/2014 2:09 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	70,669,568	0	70,669,568	0.729240	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	26,238,968	0	26,238,968	0.270760	0	2.00
3.00	Total (sum of lines 1-2)	96,908,536	0	96,908,536	1.000000	0	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	3,737,015	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	4,965,305	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	8,702,320	0	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	3,737,015	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	4,965,305	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	8,702,320	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet A-8

Date/Time Prepared:  
8/26/2014 2:09 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			3.00	4.00			
1.00	2.00	3.00	4.00	5.00			
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-5,393,927				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	16,574,352				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-386,292	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			0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-55,703	MEDICAL RECORDS & LIBRARY		16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist	A	-882,108	NONPHYSICIAN ANESTHETISTS		19.00	0	28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 TELEVISION AND RADIO SERVICES	A	-466	CAP REL COSTS-MVBLE EQUIP		2.00	9	33.00
33.01 COMMUNITY DONATIONS	A	-15,000	EMERGENCY		91.00	0	33.01

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
33.02 INTEREST INCOME UNRESTRICTED	B	-728,271	OTHER ADMINISTRATION AND GENERAL		5.04	0 33.02
33.03 PAYMENTS FOR OUTPATIENT SERVICES	B	-2,287,138	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.03
33.04 NONALLOWABLE BOND EXPENSE	A	-1,918,077	INTEREST EXPENSE		113.00	0 33.04
33.05 PURCHASE DISCOUNTS	B	-5,010	PURCHASING RECEIVING AND STORES		5.02	0 33.05
33.06 CABLE TV	A	-1,016	SUBPROVIDER - IRF		41.00	0 33.06
33.07 OFFSET OF LOBBYING EXPENSES	A	-31,973	OTHER ADMINISTRATION AND GENERAL		5.04	0 33.07
33.08 COMMUNITY DONATIONS	A	-12,372	OTHER ADMINISTRATION AND GENERAL		5.04	0 33.08
33.09 LEASEHOLD REVENUE	B	-255,053	CAP REL COSTS-BLDG & FIXT		1.00	9 33.09
33.10 DEBT FORGIVENESS	A	-1,637,705	OTHER ADMINISTRATION AND GENERAL		5.04	0 33.10
33.11 FUNDED DEPRECIATION	A	-1,578	CAP REL COSTS-BLDG & FIXT		1.00	9 33.11
33.12 REAL ESTATE TAXES	A	-86,044	OTHER ADMINISTRATION AND GENERAL		5.04	0 33.12
33.13 MEDI CAID PROVIDER TAX	A	-1,346,968	OTHER ADMINISTRATION AND GENERAL		5.04	0 33.13
33.14 MISCELLANEOUS INCOME	B	-13,540	OTHER ADMINISTRATION AND GENERAL		5.04	0 33.14
33.15 CABLE TV	A	-1,093	OTHER ADMINISTRATION AND GENERAL		5.04	0 33.15
33.16 LEASEHOLD REVENUE - EQUIPMENT	B	-24,816	CAP REL COSTS-MVBLE EQUIP		2.00	9 33.16
33.17 XRAY FILM REVENUE	B	-875	RADIOLOGY-DIAGNOSTIC		54.00	0 33.17
33.18 LOSS ON 1987 BONDS	A	66,691	CAP REL COSTS-BLDG & FIXT		1.00	9 33.18
33.19 LOSS ON 1987 BONDS	A	7,866	CAP REL COSTS-MVBLE EQUIP		2.00	9 33.19
33.20 LOSS ON 1991 BONDS	A	134,655	CAP REL COSTS-BLDG & FIXT		1.00	9 33.20
33.21 LOSS ON 1991 BONDS	A	184,736	CAP REL COSTS-MVBLE EQUIP		2.00	9 33.21
33.22 OVERPAYMENT TO BAR MED DIR COR 2014	A	4,800	OTHER ADMINISTRATION AND GENERAL		5.04	0 33.22
33.23 REAL ESTATE TAXES	A	-15,429	PHYSICIANS' PRIVATE OFFICES		192.00	0 33.23
33.24 MISCELLANEOUS INCOME	B	-199	MAINTENANCE & REPAIRS		6.00	0 33.24
33.25 COMMUNITY DONATIONS	A	-126	NURSING ADMINISTRATION		13.00	0 33.25
33.26 PERSONAL USE OF PROVIDER VEHICLES	A	-3,501	OTHER ADMINISTRATION AND GENERAL		5.04	0 33.26
33.27 COMMUNITY DONATIONS	A	-11	CARDIAC REHABILITATION		76.97	0 33.27
33.28 OVERPAYMENT TO ICU MED DIR COR 2014	A	2,340	INTENSIVE CARE UNIT		31.00	0 33.28
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,871,149				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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

Provider CCN: 140011

Period: From 04/01/2013 To 03/31/2014

Worksheet A-8-1

Date/Time Prepared: 8/26/2014 2:09 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE EXPENSE	101,587	0 1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE EXPENSE	2,179,949	0 2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE EXPENSE	3,119,393	0 3.00
4.00	5.01	DATA PROCESSING	HOME OFFICE EXPENSE	3,960,445	0 4.00
4.01	5.03	CASHIERING/ACCOUNTS RECEIVAB	HOME OFFICE EXPENSE	2,273,464	0 4.01
4.02	5.04	OTHER ADMINISTRATIVE AND GEN	HOME OFFICE EXPENSE	5,064,928	0 4.02
4.03	90.00	CLINIC	RENT	10,125	15,878 4.03
4.04	60.00	LABORATORY	RENT	34,354	69,486 4.04
4.05	54.00	RADIOLOGY-DIAGNOSTIC	RENT	43,737	107,129 4.05
4.06	66.00	PHYSICAL THERAPY	RENT	10,705	31,842 4.06
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			16,798,687	224,335 5.00

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

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

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

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

6.00	B	SIHS	100.00	SIHE	100.00	6.00
7.00	B	SIHE	100.00	SIHE	100.00	7.00
8.00	B	HSSI	100.00	SIHE	100.00	8.00
9.00	B	SIMS	100.00	SIHS	100.00	9.00
10.00	B	SIH CAYMAN	100.00	SIHS	100.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet A-8-1

Date/Time Prepared:  
8/26/2014 2:09 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	101,587	9		1.00
2.00	2,179,949	9		2.00
3.00	3,119,393	0		3.00
4.00	3,960,445	0		4.00
4.01	2,273,464	0		4.01
4.02	5,064,928	0		4.02
4.03	-5,753	0		4.03
4.04	-35,132	0		4.04
4.05	-63,392	0		4.05
4.06	-21,137	0		4.06
5.00	16,574,352			5.00

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

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

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

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

6.00	HEALTHCARE		6.00
7.00	HEALTHCARE		7.00
8.00	HEALTHCARE		8.00
9.00	HEALTHCARE		9.00
10.00	HEALTHCARE		10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet A-8-2

Date/Time Prepared:  
8/26/2014 2:09 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	DR. A	6,225	0	6,225	159,800	42	1.00
2.00	60.00	DR. B	80,000	0	80,000	208,000	710	2.00
3.00	65.00	DR. C	15,780	0	15,780	159,800	126	3.00
4.00	69.00	DR. D	136,552	133,252	3,300	159,800	30	4.00
5.00	76.97	DR. E	3,630	3,630	0	0	0	5.00
6.00	91.00	DR. F	1,655,643	1,640,808	14,835	159,800	108	6.00
7.00	30.00	DR. G	2,241,257	2,241,257	0	0	0	7.00
8.00	41.00	DR. H	1,273,627	1,273,627	0	0	0	8.00
9.00	50.00	DR. I	144,718	3,600	141,118	182,900	809	9.00
10.00	31.00	DR. J	650	0	650	159,800	5	10.00
11.00	90.00	DR. K	4,410	450	3,960	159,800	33	11.00
200.00			5,562,492	5,296,624	265,868		1,863	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	DR. A	3,227	161	0	0	0	1.00
2.00	60.00	DR. B	71,000	3,550	0	0	0	2.00
3.00	65.00	DR. C	9,680	484	0	0	0	3.00
4.00	69.00	DR. D	2,305	115	0	0	0	4.00
5.00	76.97	DR. E	0	0	0	0	0	5.00
6.00	91.00	DR. F	8,297	415	0	0	0	6.00
7.00	30.00	DR. G	0	0	0	0	0	7.00
8.00	41.00	DR. H	0	0	0	0	0	8.00
9.00	50.00	DR. I	71,137	3,557	0	0	0	9.00
10.00	31.00	DR. J	384	19	0	0	0	10.00
11.00	90.00	DR. K	2,535	127	0	0	0	11.00
200.00			168,565	8,428	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	DR. A	0	3,227	2,998	2,998		1.00
2.00	60.00	DR. B	0	71,000	9,000	9,000		2.00
3.00	65.00	DR. C	0	9,680	6,100	6,100		3.00
4.00	69.00	DR. D	0	2,305	995	134,247		4.00
5.00	76.97	DR. E	0	0	0	3,630		5.00
6.00	91.00	DR. F	0	8,297	6,538	1,647,346		6.00
7.00	30.00	DR. G	0	0	0	2,241,257		7.00
8.00	41.00	DR. H	0	0	0	1,273,627		8.00
9.00	50.00	DR. I	0	71,137	69,981	73,581		9.00
10.00	31.00	DR. J	0	384	266	266		10.00
11.00	90.00	DR. K	0	2,535	1,425	1,875		11.00
200.00			0	168,565	97,303	5,393,927		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140011

Period: From 04/01/2013 To 03/31/2014

Worksheet B Part I Date/Time Prepared: 8/26/2014 2:09 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	3,737,015	3,737,015			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	4,965,305		4,965,305		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	13,920,396	26,700	1,435	13,948,531	4.00
5.01 00550	DATA PROCESSING	3,960,445	17,434	0	0	3,977,879 5.01
5.02 00560	PURCHASING RECEIVING AND STORES	73,299	31,874	291	0	12,240 5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	3,057,655	25,735	7,528	286,398	146,876 5.03
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL	9,938,261	692,469	87,440	783,532	428,387 5.04
6.00 00600	MAINTENANCE & REPAIRS	1,856,729	397,123	31,139	224,454	36,719 6.00
8.00 00800	LAUNDRY & LINEN SERVICE	272,789	0	0	14,895	0 8.00
9.00 00900	HOUSEKEEPING	1,132,490	55,762	21,532	342,857	24,479 9.00
10.00 01000	DIETARY	540,617	54,980	38,075	126,567	61,198 10.00
11.00 01100	CAFETERIA	705,532	70,967	0	255,613	0 11.00
13.00 01300	NURSING ADMINISTRATION	1,191,993	21,959	218,659	438,034	42,839 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	232,797	36,764	23,256	71,418	12,240 14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	350,043	0	17,930	151,250	104,037 16.00
17.00 01700	SOCIAL SERVICE	0	4,691	0	0	0 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	8,919,585	552,149	330,045	2,609,286	354,949 30.00
31.00 03100	INTENSIVE CARE UNIT	1,975,783	71,217	68,915	593,361	244,793 31.00
41.00 04100	SUBPROVIDER - I/R	3,003,193	304,313	101,049	984,896	446,743 41.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	5,705,491	259,447	1,251,245	1,254,915	336,590 50.00
51.00 05100	RECOVERY ROOM	391,121	18,948	12,559	129,820	48,959 51.00
53.00 05300	ANESTHESIOLOGY	113,149	0	44,213	13,365	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,576,303	158,653	659,846	839,608	189,714 54.00
56.00 05600	RADIOISOTOPE	1,635,618	26,384	327,749	123,197	48,959 56.00
57.00 05700	CT SCAN	843,192	16,968	305,704	179,327	12,240 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	425,099	12,876	377,396	99,234	6,120 58.00
60.00 06000	LABORATORY	5,150,406	113,620	355,723	694,200	269,272 60.00
65.00 06500	RESPIRATORY THERAPY	1,389,550	51,853	114,161	440,741	152,995 65.00
66.00 06600	PHYSICAL THERAPY	3,046,668	212,618	77,652	1,015,757	403,908 66.00
69.00 06900	ELECTROCARDIOLOGY	716,452	21,393	223,830	231,401	122,396 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,658,576	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	3,566,481	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	5,707,388	33,787	36,317	733,758	85,677 73.00
76.97 07697	CARDIAC REHABILITATION	414,862	33,670	13,621	154,605	48,959 76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	546,529	0	0	66,494	73,438 90.00
91.00 09100	EMERGENCY	3,970,362	162,479	206,736	1,089,548	201,954 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	100,691,174	3,486,833	4,954,046	13,948,531	3,916,681 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,817	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	91,662	0	11,259	0	61,198 192.00
192.01 19201	VACANT SPACE	0	232,365	0	0	0 192.01
192.02 19202	REFERENCE LAB	0	0	0	0	0 192.02
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	100,782,836	3,737,015	4,965,305	13,948,531	3,977,879 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet B  
Part I  
Date/Time Prepared:  
8/26/2014 2:09 pm

Cost Center Description			PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.02	5.03	5A.03	5.04	6.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	117,704					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	3,524,192				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	505	0	11,930,594	11,930,594		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	2,546,164	341,886	2,888,050	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	287,684	38,629	0	8.00
9.00	00900	HOUSEKEEPING	5	0	1,577,125	211,768	63,262	9.00
10.00	01000	DIETARY	7	0	821,444	110,299	62,375	10.00
11.00	01100	CAFETERIA	14	0	1,032,126	138,589	80,511	11.00
13.00	01300	NURSING ADMINISTRATION	13	0	1,913,497	256,935	24,912	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	119	0	376,594	50,567	41,709	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	623,260	83,688	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	4,691	630	5,322	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	24,522	157,619	12,948,155	1,738,575	626,408	30.00
31.00	03100	INTENSIVE CARE UNIT	7,066	22,148	2,983,283	400,580	80,795	31.00
41.00	04100	SUBPROVIDER - IRF	3,482	107,424	4,951,100	664,809	345,240	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	52,654	453,662	9,314,004	1,250,638	294,340	50.00
51.00	05100	RECOVERY ROOM	685	31,700	633,792	85,102	21,496	51.00
53.00	05300	ANESTHESIOLOGY	2,324	59,903	232,954	31,280	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	914	205,622	4,630,660	621,782	179,990	54.00
56.00	05600	RADIOISOTOPE	371	191,729	2,354,007	316,084	29,932	56.00
57.00	05700	CT SCAN	2,662	434,570	1,794,663	240,978	19,250	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	162	124,290	1,045,177	140,341	14,608	58.00
60.00	06000	LABORATORY	3,536	631,838	7,218,595	969,277	128,901	60.00
65.00	06500	RESPIRATORY THERAPY	1,671	59,173	2,210,144	296,767	58,827	65.00
66.00	06600	PHYSICAL THERAPY	186	139,361	4,896,150	657,431	241,213	66.00
69.00	06900	ELECTROCARDIOLOGY	559	150,734	1,466,765	196,950	24,270	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	246,762	4,905,338	658,664	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	3,566,481	478,889	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,281	254,505	6,853,713	920,282	38,331	73.00
76.97	07697	CARDIAC REHABILITATION	73	14,644	680,434	91,365	38,199	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	898	18,080	705,439	94,723	0	90.00
91.00	09100	EMERGENCY	12,995	220,428	5,864,502	787,456	184,331	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	117,704	3,524,192	100,368,535	11,874,964	2,604,222	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	17,817	2,392	20,213	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	164,119	22,037	0	192.00
192.01	19201	VACANT SPACE	0	0	232,365	31,201	263,615	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	117,704	3,524,192	100,782,836	11,930,594	2,888,050	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet B  
Part I  
Date/Time Prepared:  
8/26/2014 2:09 pm

Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION		
		8.00	9.00	10.00	11.00	13.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	00550	DATA PROCESSING					5.01	
5.02	00560	PURCHASING RECEIVING AND STORES					5.02	
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03	
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL					5.04	
6.00	00600	MAINTENANCE & REPAIRS					6.00	
8.00	00800	LAUNDRY & LINEN SERVICE	326,313				8.00	
9.00	00900	HOUSEKEEPING	0	1,852,155			9.00	
10.00	01000	DIETARY	0	40,898	1,035,016		10.00	
11.00	01100	CAFETERIA	0	52,790	0	1,304,016	11.00	
13.00	01300	NURSING ADMINISTRATION	0	16,334	0	47,943	2,259,621	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	27,348	0	7,817	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	16,554	0	16.00
17.00	01700	SOCIAL SERVICE	0	3,490	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	208,880	410,720	662,535	285,586	1,064,528	30.00
31.00	03100	INTENSIVE CARE UNIT	26,524	52,975	84,131	64,944	301,900	31.00
41.00	04100	SUBPROVIDER - I RF	90,909	226,367	288,350	107,797	184,842	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	192,993	0	137,351	7,254	50.00
51.00	05100	RECOVERY ROOM	0	14,095	0	14,209	7,003	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,463	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	118,016	0	91,896	0	54.00
56.00	05600	RADIOISOTOPE	0	19,626	0	13,484	0	56.00
57.00	05700	CT SCAN	0	12,622	0	19,627	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	9,578	0	10,861	0	58.00
60.00	06000	LABORATORY	0	84,518	0	75,981	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	38,571	0	48,239	0	65.00
66.00	06600	PHYSICAL THERAPY	0	158,159	0	111,175	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	15,914	0	25,327	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,133	0	80,310	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	25,046	0	16,922	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	7,278	0	90.00
91.00	09100	EMERGENCY	0	120,862	0	119,252	694,094	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	326,313	1,666,055	1,035,016	1,304,016	2,259,621	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,253	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	VACANT SPACE	0	172,847	0	0	0	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
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)	326,313	1,852,155	1,035,016	1,304,016	2,259,621	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet B  
Part I  
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Cost Center Description		CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
		14.00	16.00	17.00	19.00	24.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00550						5.01
5.02	00560						5.02
5.03	00580						5.03
5.04	00590						5.04
6.00	00600						6.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400	504,035					14.00
16.00	01600	0	723,502				16.00
17.00	01700	0	0	14,133			17.00
19.00	01900	0	0	0	0		19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	150	32,353	9,047	0	17,986,937	30.00
31.00	03100	191	4,546	1,149	0	4,001,018	31.00
41.00	04100	71	22,050	3,937	0	6,885,472	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	452,606	93,118	0	0	11,742,304	50.00
51.00	05100	0	6,507	0	0	782,204	51.00
53.00	05300	2,908	12,296	0	0	280,901	53.00
54.00	05400	150	42,206	0	0	5,684,700	54.00
56.00	05600	19	39,354	0	0	2,772,506	56.00
57.00	05700	1	89,199	0	0	2,176,340	57.00
58.00	05800	372	25,512	0	0	1,246,449	58.00
60.00	06000	41,223	129,818	0	0	8,648,313	60.00
65.00	06500	4,718	12,146	0	0	2,669,412	65.00
66.00	06600	17	28,605	0	0	6,092,750	66.00
69.00	06900	11	30,940	0	0	1,760,177	69.00
71.00	07100	122	50,650	0	0	5,614,774	71.00
72.00	07200	0	0	0	0	4,045,370	72.00
73.00	07300	43	52,240	0	0	7,970,052	73.00
76.97	07697	0	3,006	0	0	854,972	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	1,056	3,711	0	0	812,207	90.00
91.00	09100	377	45,245	0	0	7,816,119	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		504,035	723,502	14,133	0	99,842,977	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	53,675	190.00
192.00	19200	0	0	0	0	186,156	192.00
192.01	19201	0	0	0	0	700,028	192.01
192.02	19202	0	0	0	0	0	192.02
200.00						0	200.00
201.00		0	0	0	0	0	201.00
202.00		504,035	723,502	14,133	0	100,782,836	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet B  
Part I  
Date/Time Prepared:  
8/26/2014 2:09 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total		
		25.00	26.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00	
5.01	00550	DATA PROCESSING		5.01	
5.02	00560	PURCHASING RECEIVING AND STORES		5.02	
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE		5.03	
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL		5.04	
6.00	00600	MAINTENANCE & REPAIRS		6.00	
8.00	00800	LAUNDRY & LINEN SERVICE		8.00	
9.00	00900	HOUSEKEEPING		9.00	
10.00	01000	DIETARY		10.00	
11.00	01100	CAFETERIA		11.00	
13.00	01300	NURSING ADMINISTRATION		13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00	
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00	
17.00	01700	SOCIAL SERVICE		17.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	0	17,986,937	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,001,018	31.00
41.00	04100	SUBPROVIDER - I RF	0	6,885,472	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	11,742,304	50.00
51.00	05100	RECOVERY ROOM	0	782,204	51.00
53.00	05300	ANESTHESIOLOGY	0	280,901	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,684,700	54.00
56.00	05600	RADIOISOTOPE	0	2,772,506	56.00
57.00	05700	CT SCAN	0	2,176,340	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,246,449	58.00
60.00	06000	LABORATORY	0	8,648,313	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,669,412	65.00
66.00	06600	PHYSICAL THERAPY	0	6,092,750	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,760,177	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,614,774	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,045,370	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,970,052	73.00
76.97	07697	CARDIAC REHABILITATION	0	854,972	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	812,207	90.00
91.00	09100	EMERGENCY	0	7,816,119	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	99,842,977	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	53,675	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	186,156	192.00
192.01	19201	VACANT SPACE	0	700,028	192.01
192.02	19202	REFERENCE LAB	0	0	192.02
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	100,782,836	202.00

COST ALLOCATION STATISTICS

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet Non-CMS W  
Date/Time Prepared:  
8/26/2014 2:09 pm

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES	4.00
5.01	DATA PROCESSING	5	NUMBER OF PCS	5.01
5.02	PURCHASING RECEIVING AND STORES	6	PURCHASING SUPPLIES	5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	7	GROSS REVENUE	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	-5	ACCUM. COST	5.04
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
8.00	LAUNDRY & LINEN SERVICE	8	PATIENT DAYS	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	9	HOURS OF SERVICE	10.00
11.00	CAFETERIA	4	GROSS SALARIES	11.00
13.00	NURSING ADMINISTRATION	10	DIRECT NURSING HRS.	13.00
14.00	CENTRAL SERVICES & SUPPLY	11	COSTED REQUIS.	14.00
16.00	MEDICAL RECORDS & LIBRARY	7	GROSS REVENUE	16.00
17.00	SOCIAL SERVICE	8	PATIENT DAYS	17.00
19.00	NONPHYSICIAN ANESTHETISTS	19	ASSIGNED TIME	19.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet B  
Part II  
Date/Time Prepared:  
8/26/2014 2:09 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	26,700	1,435	28,135	4.00
5.01 00550	DATA PROCESSING	0	17,434	0	17,434	5.01
5.02 00560	PURCHASING RECEIVING AND STORES	0	31,874	291	32,165	5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	25,735	7,528	33,263	5.03
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL	0	692,469	87,440	779,909	5.04
6.00 00600	MAINTENANCE & REPAIRS	0	397,123	31,139	428,262	6.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	55,762	21,532	77,294	9.00
10.00 01000	DIETARY	0	54,980	38,075	93,055	10.00
11.00 01100	CAFETERIA	0	70,967	0	70,967	11.00
13.00 01300	NURSING ADMINISTRATION	0	21,959	218,659	240,618	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	36,764	23,256	60,020	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	17,930	17,930	16.00
17.00 01700	SOCIAL SERVICE	0	4,691	0	4,691	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	552,149	330,045	882,194	30.00
31.00 03100	INTENSIVE CARE UNIT	0	71,217	68,915	140,132	31.00
41.00 04100	SUBPROVIDER - IRF	0	304,313	101,049	405,362	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	259,447	1,251,245	1,510,692	50.00
51.00 05100	RECOVERY ROOM	0	18,948	12,559	31,507	51.00
53.00 05300	ANESTHESIOLOGY	0	0	44,213	44,213	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	158,653	659,846	818,499	54.00
56.00 05600	RADIOISOTOPE	0	26,384	327,749	354,133	56.00
57.00 05700	CT SCAN	0	16,968	305,704	322,672	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	12,876	377,396	390,272	58.00
60.00 06000	LABORATORY	0	113,620	355,723	469,343	60.00
65.00 06500	RESPIRATORY THERAPY	0	51,853	114,161	166,014	65.00
66.00 06600	PHYSICAL THERAPY	0	212,618	77,652	290,270	66.00
69.00 06900	ELECTROCARDIOLOGY	0	21,393	223,830	245,223	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	33,787	36,317	70,104	73.00
76.97 07697	CARDIAC REHABILITATION	0	33,670	13,621	47,291	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	162,479	206,736	369,215	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	3,486,833	4,954,046	8,440,879	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,817	0	17,817	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	11,259	11,259	192.00
192.01 19201	VACANT SPACE	0	232,365	0	232,365	192.01
192.02 19202	REFERENCE LAB	0	0	0	0	192.02
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	3,737,015	4,965,305	8,702,320	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet B  
Part II  
Date/Time Prepared:  
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Cost Center Description		DATA PROCESSING	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
		5.01	5.02	5.03	5.04	6.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00550	17,434					5.01
5.02	00560	54	32,219				5.02
5.03	00580	644	0	34,485			5.03
5.04	00590	1,878	138	0	783,505		5.04
6.00	00600	161	0	0	22,452	451,328	6.00
8.00	00800	0	0	0	2,537	0	8.00
9.00	00900	107	1	0	13,907	9,886	9.00
10.00	01000	268	2	0	7,243	9,748	10.00
11.00	01100	0	4	0	9,101	12,582	11.00
13.00	01300	188	4	0	16,873	3,893	13.00
14.00	01400	54	33	0	3,321	6,518	14.00
16.00	01600	456	0	0	5,496	0	16.00
17.00	01700	0	0	0	41	832	17.00
19.00	01900	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	1,556	6,712	1,535	114,184	97,892	30.00
31.00	03100	1,073	1,934	216	26,307	12,626	31.00
41.00	04100	1,955	953	1,046	43,659	53,952	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	1,475	14,414	4,418	82,131	45,998	50.00
51.00	05100	215	187	309	5,589	3,359	51.00
53.00	05300	0	636	583	2,054	0	53.00
54.00	05400	831	250	2,003	40,833	28,128	54.00
56.00	05600	215	102	1,867	20,758	4,678	56.00
57.00	05700	54	729	4,232	15,825	3,008	57.00
58.00	05800	27	44	1,211	9,216	2,283	58.00
60.00	06000	1,180	968	6,316	63,654	20,144	60.00
65.00	06500	671	457	576	19,489	9,193	65.00
66.00	06600	1,770	51	1,357	43,174	37,695	66.00
69.00	06900	536	153	1,468	12,934	3,793	69.00
71.00	07100	0	0	2,403	43,255	0	71.00
72.00	07200	0	0	0	31,449	0	72.00
73.00	07300	376	624	2,479	60,436	5,990	73.00
76.97	07697	215	20	143	6,000	5,969	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	322	246	176	6,221	0	90.00
91.00	09100	885	3,557	2,147	51,713	28,806	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		17,166	32,219	34,485	779,852	406,973	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	157	3,159	190.00
192.00	19200	268	0	0	1,447	0	192.00
192.01	19201	0	0	0	2,049	41,196	192.01
192.02	19202	0	0	0	0	0	192.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		17,434	32,219	34,485	783,505	451,328	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet B  
Part II  
Date/Time Prepared:  
8/26/2014 2:09 pm

Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	DATA PROCESSING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,567				8.00
9.00	00900	HOUSEKEEPING	0	101,886			9.00
10.00	01000	DIETARY	0	2,250	112,821		10.00
11.00	01100	CAFETERIA	0	2,904	0	96,074	11.00
13.00	01300	NURSING ADMINISTRATION	0	899	0	3,533	266,891
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,504	0	576	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,220	0
17.00	01700	SOCIAL SERVICE	0	192	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	1,643	22,594	72,219	21,034	125,735
31.00	03100	INTENSIVE CARE UNIT	209	2,914	9,171	4,785	35,658
41.00	04100	SUBPROVIDER - I RF	715	12,452	31,431	7,943	21,832
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	10,616	0	10,120	857
51.00	05100	RECOVERY ROOM	0	775	0	1,047	827
53.00	05300	ANESTHESIOLOGY	0	0	0	108	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,492	0	6,771	0
56.00	05600	RADIOISOTOPE	0	1,080	0	994	0
57.00	05700	CT SCAN	0	694	0	1,446	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	527	0	800	0
60.00	06000	LABORATORY	0	4,649	0	5,598	0
65.00	06500	RESPIRATORY THERAPY	0	2,122	0	3,554	0
66.00	06600	PHYSICAL THERAPY	0	8,700	0	8,192	0
69.00	06900	ELECTROCARDIOLOGY	0	875	0	1,866	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,383	0	5,917	0
76.97	07697	CARDIAC REHABILITATION	0	1,378	0	1,247	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	536	0
91.00	09100	EMERGENCY	0	6,649	0	8,787	81,982
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,567	91,649	112,821	96,074	266,891
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	729	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	VACANT SPACE	0	9,508	0	0	0
192.02	19202	REFERENCE LAB	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	2,567	101,886	112,821	96,074	266,891

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140011		Period: From 04/01/2013 To 03/31/2014		Worksheet B Part II Date/Time Prepared: 8/26/2014 2:09 pm	
Cost Center Description			CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			14.00	16.00	17.00	19.00	24.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	72,170					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	25,407				16.00
17.00	01700	SOCIAL SERVICE	0	0	5,756			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	21	1,132	3,684		1,357,401	30.00
31.00	03100	INTENSIVE CARE UNIT	27	159	468		236,876	31.00
41.00	04100	SUBPROVIDER - I RF	10	772	1,604		585,672	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	64,808	3,259	0		1,751,319	50.00
51.00	05100	RECOVERY ROOM	0	228	0		44,305	51.00
53.00	05300	ANESTHESIOLOGY	416	430	0		48,467	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22	1,477	0		906,999	54.00
56.00	05600	RADIOISOTOPE	3	1,377	0		385,455	56.00
57.00	05700	CT SCAN	0	3,121	0		352,143	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	53	893	0		405,526	58.00
60.00	06000	LABORATORY	5,902	4,632	0		583,786	60.00
65.00	06500	RESPIRATORY THERAPY	676	425	0		204,066	65.00
66.00	06600	PHYSICAL THERAPY	2	1,001	0		394,261	66.00
69.00	06900	ELECTROCARDIOLOGY	2	1,083	0		268,400	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17	1,772	0		47,447	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		31,449	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6	1,828	0		150,623	73.00
76.97	07697	CARDIAC REHABILITATION	0	105	0		62,680	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	151	130	0		7,916	90.00
91.00	09100	EMERGENCY	54	1,583	0		557,575	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	72,170	25,407	5,756	0	8,382,366	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		21,862	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		12,974	192.00
192.01	19201	VACANT SPACE	0	0	0		285,118	192.01
192.02	19202	REFERENCE LAB	0	0	0		0	192.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	72,170	25,407	5,756	0	8,702,320	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140011	Period: From 04/01/2013 To 03/31/2014	Worksheet B Part II Date/Time Prepared: 8/26/2014 2:09 pm
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00550	DATA PROCESSING		5.01
5.02	00560	PURCHASING RECEIVING AND STORES		5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE		5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL		5.04
6.00	00600	MAINTENANCE & REPAIRS		6.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	0	1,357,401
31.00	03100	INTENSIVE CARE UNIT	0	236,876
41.00	04100	SUBPROVIDER - I RF	0	585,672
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	0	1,751,319
51.00	05100	RECOVERY ROOM	0	44,305
53.00	05300	ANESTHESIOLOGY	0	48,467
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	906,999
56.00	05600	RADIOISOTOPE	0	385,455
57.00	05700	CT SCAN	0	352,143
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	405,526
60.00	06000	LABORATORY	0	583,786
65.00	06500	RESPIRATORY THERAPY	0	204,066
66.00	06600	PHYSICAL THERAPY	0	394,261
69.00	06900	ELECTROCARDIOLOGY	0	268,400
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	47,447
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	31,449
73.00	07300	DRUGS CHARGED TO PATIENTS	0	150,623
76.97	07697	CARDIAC REHABILITATION	0	62,680
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000	CLINIC	0	7,916
91.00	09100	EMERGENCY	0	557,575
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	8,382,366
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21,862
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	12,974
192.01	19201	VACANT SPACE	0	285,118
192.02	19202	REFERENCE LAB	0	0
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	8,702,320

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet B-1

Date/Time Prepared:  
8/26/2014 2:09 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (NUMBER OF PCS)	PURCHASING RECEIVING AND STORES (PURCHASING SUPPLIES)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	224,641				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		2,505,032			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,605	724	35,207,691		4.00
5.01 00550	DATA PROCESSING	1,048	0	0	650	5.01
5.02 00560	PURCHASING RECEIVING AND STORES	1,916	147	0	2	4,800,910
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	1,547	3,798	722,900	24	0
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL	41,626	44,114	1,977,722	70	20,599
6.00 00600	MAINTENANCE & REPAIRS	23,872	15,710	566,547	6	0
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	37,596	0	0
9.00 00900	HOUSEKEEPING	3,352	10,863	865,410	4	221
10.00 01000	DIETARY	3,305	19,209	319,470	10	277
11.00 01100	CAFETERIA	4,266	0	645,196	0	560
13.00 01300	NURSING ADMINISTRATION	1,320	110,315	1,105,646	7	531
14.00 01400	CENTRAL SERVICES & SUPPLY	2,210	11,733	180,266	2	4,859
16.00 01600	MEDICAL RECORDS & LIBRARY	0	9,046	381,772	17	5
17.00 01700	SOCIAL SERVICE	282	0	0	0	0
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	33,191	166,510	6,586,176	58	1,000,218
31.00 03100	INTENSIVE CARE UNIT	4,281	34,768	1,497,709	40	288,219
41.00 04100	SUBPROVIDER - I/R	18,293	50,980	2,485,987	73	142,006
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	15,596	631,261	3,167,545	55	2,147,685
51.00 05100	RECOVERY ROOM	1,139	6,336	327,681	8	27,924
53.00 05300	ANESTHESIOLOGY	0	22,306	33,734	0	94,771
54.00 05400	RADIOLOGY-DIAGNOSTIC	9,537	332,897	2,119,264	31	37,299
56.00 05600	RADIOISOTOPE	1,586	165,352	310,963	8	15,144
57.00 05700	CT SCAN	1,020	154,230	452,642	2	108,583
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	774	190,399	250,477	1	6,589
60.00 06000	LABORATORY	6,830	179,465	1,752,237	44	144,229
65.00 06500	RESPIRATORY THERAPY	3,117	57,595	1,112,480	25	68,163
66.00 06600	PHYSICAL THERAPY	12,781	39,176	2,563,883	66	7,574
69.00 06900	ELECTROCARDIOLOGY	1,286	112,924	584,081	20	22,803
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	2,031	18,322	1,852,086	14	93,027
76.97 07697	CARDIAC REHABILITATION	2,024	6,872	390,241	8	2,961
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	167,839	12	36,631
91.00 09100	EMERGENCY	9,767	104,300	2,750,141	33	530,032
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	209,602	2,499,352	35,207,691	640	4,800,910
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,071	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	5,680	0	10	0
192.01 19201	VACANT SPACE	13,968	0	0	0	0
192.02 19202	REFERENCE LAB	0	0	0	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	3,737,015	4,965,305	13,948,531	3,977,879	117,704
203.00	Unit cost multiplier (Wkst. B, Part I)	16.635498	1.982132	0.396179	6,119.813846	0.024517
204.00	Cost to be allocated (per Wkst. B, Part II)			28,135	17,434	32,219
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000799	26.821538	0.006711

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140011

Period: From 04/01/2013 To 03/31/2014

Worksheet B-1

Date/Time Prepared: 8/26/2014 2:09 pm

Cost Center Description		CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	
		5.03	5A.04	5.04	6.00	8.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00550						5.01
5.02	00560						5.02
5.03	00580	429,036,497					5.03
5.04	00590	0	-11,930,594	88,852,242			5.04
6.00	00600	0	0	2,546,164	153,027		6.00
8.00	00800	0	0	287,684	0	25,503	8.00
9.00	00900	0	0	1,577,125	3,352	0	9.00
10.00	01000	0	0	821,444	3,305	0	10.00
11.00	01100	0	0	1,032,126	4,266	0	11.00
13.00	01300	0	0	1,913,497	1,320	0	13.00
14.00	01400	0	0	376,594	2,210	0	14.00
16.00	01600	0	0	623,260	0	0	16.00
17.00	01700	0	0	4,691	282	0	17.00
19.00	01900	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	19,189,042	0	12,948,155	33,191	16,325	30.00
31.00	03100	2,696,360	0	2,983,283	4,281	2,073	31.00
41.00	04100	13,078,101	0	4,951,100	18,293	7,105	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	55,230,304	0	9,314,004	15,596	0	50.00
51.00	05100	3,859,274	0	633,792	1,139	0	51.00
53.00	05300	7,292,749	0	232,954	0	0	53.00
54.00	05400	25,033,093	0	4,630,660	9,537	0	54.00
56.00	05600	23,341,712	0	2,354,007	1,586	0	56.00
57.00	05700	52,905,962	0	1,794,663	1,020	0	57.00
58.00	05800	15,131,526	0	1,045,177	774	0	58.00
60.00	06000	76,911,648	0	7,218,595	6,830	0	60.00
65.00	06500	7,203,951	0	2,210,144	3,117	0	65.00
66.00	06600	16,966,280	0	4,896,150	12,781	0	66.00
69.00	06900	18,350,907	0	1,466,765	1,286	0	69.00
71.00	07100	30,041,650	0	4,905,338	0	0	71.00
72.00	07200	0	0	3,566,481	0	0	72.00
73.00	07300	30,984,352	0	6,853,713	2,031	0	73.00
76.97	07697	1,782,867	0	680,434	2,024	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	2,201,085	0	705,439	0	0	90.00
91.00	09100	26,835,634	0	5,864,502	9,767	0	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		429,036,497	-11,930,594	88,437,941	137,988	25,503	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	17,817	1,071	0	190.00
192.00	19200	0	0	164,119	0	0	192.00
192.01	19201	0	0	232,365	13,968	0	192.01
192.02	19202	0	0	0	0	0	192.02
200.00							200.00
201.00							201.00
202.00		3,524,192		11,930,594	2,888,050	326,313	202.00
203.00		0.008214		0.134275	18.872813	12.795083	203.00
204.00		34,485		783,505	451,328	2,567	204.00
205.00		0.000080		0.008818	2.949336	0.100655	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet B-1

Date/Time Prepared:  
8/26/2014 2:09 pm

Cost Center Description		HOUSEKEEPING (SQUARE FEET)	DIETARY (HOURS OF SERVICE)	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (DIRECT NURSING HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00550						5.01
5.02	00560						5.02
5.03	00580						5.03
5.04	00590						5.04
6.00	00600						6.00
8.00	00800						8.00
9.00	00900	149,675					9.00
10.00	01000	3,305	76,509				10.00
11.00	01100	4,266	0	30,072,850			11.00
13.00	01300	1,320	0	1,105,646	45,170		13.00
14.00	01400	2,210	0	180,266	0	8,905,322	14.00
16.00	01600	0	0	381,772	0	0	16.00
17.00	01700	282	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	33,191	48,975	6,586,176	21,280	2,646	30.00
31.00	03100	4,281	6,219	1,497,709	6,035	3,367	31.00
41.00	04100	18,293	21,315	2,485,987	3,695	1,261	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	15,596	0	3,167,545	145	7,996,655	50.00
51.00	05100	1,139	0	327,681	140	0	51.00
53.00	05300	0	0	33,734	0	51,384	53.00
54.00	05400	9,537	0	2,119,264	0	2,659	54.00
56.00	05600	1,586	0	310,963	0	340	56.00
57.00	05700	1,020	0	452,642	0	21	57.00
58.00	05800	774	0	250,477	0	6,570	58.00
60.00	06000	6,830	0	1,752,237	0	728,343	60.00
65.00	06500	3,117	0	1,112,480	0	83,359	65.00
66.00	06600	12,781	0	2,563,883	0	304	66.00
69.00	06900	1,286	0	584,081	0	193	69.00
71.00	07100	0	0	0	0	2,152	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	2,031	0	1,852,086	0	754	73.00
76.97	07697	2,024	0	390,241	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	167,839	0	18,655	90.00
91.00	09100	9,767	0	2,750,141	13,875	6,659	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		134,636	76,509	30,072,850	45,170	8,905,322	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	1,071	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	13,968	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
200.00							200.00
201.00							201.00
202.00		1,852,155	1,035,016	1,304,016	2,259,621	504,035	202.00
203.00		12.374511	13.528029	0.043362	50.024817	0.056599	203.00
204.00		101,886	112,821	96,074	266,891	72,170	204.00
205.00		0.680715	1.474611	0.003195	5.908590	0.008104	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet B-1  
Date/Time Prepared:  
8/26/2014 2:09 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		16.00	17.00	19.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00550	DATA PROCESSING			5.01
5.02	00560	PURCHASING RECEIVING AND STORES			5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL			5.04
6.00	00600	MAINTENANCE & REPAIRS			6.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	429,036,497		16.00
17.00	01700	SOCIAL SERVICE	0	25,503	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	19,189,042	16,325	30.00
31.00	03100	INTENSIVE CARE UNIT	2,696,360	2,073	31.00
41.00	04100	SUBPROVIDER - IRF	13,078,101	7,105	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	55,230,304	0	50.00
51.00	05100	RECOVERY ROOM	3,859,274	0	51.00
53.00	05300	ANESTHESIOLOGY	7,292,749	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,033,093	0	54.00
56.00	05600	RADIOISOTOPE	23,341,712	0	56.00
57.00	05700	CT SCAN	52,905,962	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	15,131,526	0	58.00
60.00	06000	LABORATORY	76,911,648	0	60.00
65.00	06500	RESPIRATORY THERAPY	7,203,951	0	65.00
66.00	06600	PHYSICAL THERAPY	16,966,280	0	66.00
69.00	06900	ELECTROCARDIOLOGY	18,350,907	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	30,041,650	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,984,352	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,782,867	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	2,201,085	0	90.00
91.00	09100	EMERGENCY	26,835,634	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	429,036,497	25,503	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	VACANT SPACE	0	0	192.01
192.02	19202	REFERENCE LAB	0	0	192.02
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	723,502	14,133	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.001686	0.554170	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	25,407	5,756	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000059	0.225699	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet C  
Part I  
Date/Time Prepared:  
8/26/2014 2:09 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	17,986,937		17,986,937	2,998	17,989,935	30.00
31.00	03100 INTENSIVE CARE UNIT	4,001,018		4,001,018	266	4,001,284	31.00
41.00	04100 SUBPROVIDER - I RF	6,885,472		6,885,472	0	6,885,472	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	11,742,304		11,742,304	69,981	11,812,285	50.00
51.00	05100 RECOVERY ROOM	782,204		782,204	0	782,204	51.00
53.00	05300 ANESTHESIOLOGY	280,901		280,901	0	280,901	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,684,700		5,684,700	0	5,684,700	54.00
56.00	05600 RADIOISOTOPE	2,772,506		2,772,506	0	2,772,506	56.00
57.00	05700 CT SCAN	2,176,340		2,176,340	0	2,176,340	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,246,449		1,246,449	0	1,246,449	58.00
60.00	06000 LABORATORY	8,648,313		8,648,313	9,000	8,657,313	60.00
65.00	06500 RESPIRATORY THERAPY	2,669,412	0	2,669,412	6,100	2,675,512	65.00
66.00	06600 PHYSICAL THERAPY	6,092,750	0	6,092,750	0	6,092,750	66.00
69.00	06900 ELECTROCARDIOLOGY	1,760,177		1,760,177	995	1,761,172	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5,614,774		5,614,774	0	5,614,774	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	4,045,370		4,045,370	0	4,045,370	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7,970,052		7,970,052	0	7,970,052	73.00
76.97	07697 CARDIAC REHABILITATION	854,972		854,972	0	854,972	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	812,207		812,207	1,425	813,632	90.00
91.00	09100 EMERGENCY	7,816,119		7,816,119	6,538	7,822,657	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,520,589		2,520,589		2,520,589	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	102,363,566	0	102,363,566	97,303	102,460,869	200.00
201.00	Less Observation Beds	2,520,589		2,520,589		2,520,589	201.00
202.00	Total (see instructions)	99,842,977	0	99,842,977	97,303	99,940,280	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet C  
Part I  
Date/Time Prepared:  
8/26/2014 2:09 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	15,158,324		15,158,324		30.00
31.00	03100	INTENSIVE CARE UNIT	2,696,360		2,696,360		31.00
41.00	04100	SUBPROVIDER - IRF	11,854,406		11,854,406		41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	25,631,149	29,095,034	54,726,183	0.214565	50.00
51.00	05100	RECOVERY ROOM	2,381,800	1,301,174	3,682,974	0.212384	51.00
53.00	05300	ANESTHESIOLOGY	3,804,161	3,417,641	7,221,802	0.038896	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,775,089	20,926,517	24,701,606	0.230135	54.00
56.00	05600	RADIOISOTOPE	2,401,983	20,771,657	23,173,640	0.119641	56.00
57.00	05700	CT SCAN	10,192,479	42,315,458	52,507,937	0.041448	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,398,559	13,472,219	14,870,778	0.083819	58.00
60.00	06000	LABORATORY	21,568,671	54,735,435	76,304,106	0.113340	60.00
65.00	06500	RESPIRATORY THERAPY	5,626,453	1,560,654	7,187,107	0.371417	65.00
66.00	06600	PHYSICAL THERAPY	8,186,595	8,389,744	16,576,339	0.367557	66.00
69.00	06900	ELECTROCARDIOLOGY	5,043,518	12,031,002	17,074,520	0.103088	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,722,451	5,362,568	17,085,019	0.328637	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,169,224	2,641,746	12,810,970	0.315774	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,704,195	10,151,311	30,855,506	0.258302	73.00
76.97	07697	CARDIAC REHABILITATION	3,120	1,766,883	1,770,003	0.483034	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	19,484	2,179,254	2,198,738	0.369397	90.00
91.00	09100	EMERGENCY	4,761,715	21,893,942	26,655,657	0.293226	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	146,594	3,848,636	3,995,230	0.630900	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	167,246,330	255,860,875	423,107,205		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	167,246,330	255,860,875	423,107,205		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet C  
Part I  
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
41.00	04100 SUBPROVIDER - IRF				41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.215843			50.00
51.00	05100 RECOVERY ROOM	0.212384			51.00
53.00	05300 ANESTHESIOLOGY	0.038896			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.230135			54.00
56.00	05600 RADIOISOTOPE	0.119641			56.00
57.00	05700 CT SCAN	0.041448			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.083819			58.00
60.00	06000 LABORATORY	0.113458			60.00
65.00	06500 RESPIRATORY THERAPY	0.372266			65.00
66.00	06600 PHYSICAL THERAPY	0.367557			66.00
69.00	06900 ELECTROCARDIOLOGY	0.103146			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.328637			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.315774			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.258302			73.00
76.97	07697 CARDIAC REHABILITATION	0.483034			76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.370045			90.00
91.00	09100 EMERGENCY	0.293471			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.630900			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet C  
Part I  
Date/Time Prepared:  
8/26/2014 2:09 pm

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS	17,986,937	17,986,937	2,998	17,989,935	30.00
31.00	03100 INTENSIVE CARE UNIT	4,001,018	4,001,018	266	4,001,284	31.00
41.00	04100 SUBPROVIDER - I RF	6,885,472	6,885,472	0	6,885,472	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	11,742,304	11,742,304	69,981	11,812,285	50.00
51.00	05100 RECOVERY ROOM	782,204	782,204	0	782,204	51.00
53.00	05300 ANESTHESIOLOGY	280,901	280,901	0	280,901	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,684,700	5,684,700	0	5,684,700	54.00
56.00	05600 RADIOISOTOPE	2,772,506	2,772,506	0	2,772,506	56.00
57.00	05700 CT SCAN	2,176,340	2,176,340	0	2,176,340	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,246,449	1,246,449	0	1,246,449	58.00
60.00	06000 LABORATORY	8,648,313	8,648,313	9,000	8,657,313	60.00
65.00	06500 RESPIRATORY THERAPY	2,669,412	2,669,412	6,100	2,675,512	65.00
66.00	06600 PHYSICAL THERAPY	6,092,750	6,092,750	0	6,092,750	66.00
69.00	06900 ELECTROCARDIOLOGY	1,760,177	1,760,177	995	1,761,172	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5,614,774	5,614,774	0	5,614,774	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	4,045,370	4,045,370	0	4,045,370	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7,970,052	7,970,052	0	7,970,052	73.00
76.97	07697 CARDIAC REHABILITATION	854,972	854,972	0	854,972	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	812,207	812,207	1,425	813,632	90.00
91.00	09100 EMERGENCY	7,816,119	7,816,119	6,538	7,822,657	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,520,589	2,520,589		2,520,589	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	102,363,566	102,363,566	97,303	102,460,869	200.00
201.00	Less Observation Beds	2,520,589	2,520,589		2,520,589	201.00
202.00	Total (see instructions)	99,842,977	99,842,977	97,303	99,940,280	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet C  
Part I  
Date/Time Prepared:  
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Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XIX Hospital							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	15,158,324		15,158,324		30.00
31.00	03100	INTENSIVE CARE UNIT	2,696,360		2,696,360		31.00
41.00	04100	SUBPROVIDER - IRF	11,854,406		11,854,406		41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	25,631,149	29,095,034	54,726,183	0.214565	50.00
51.00	05100	RECOVERY ROOM	2,381,800	1,301,174	3,682,974	0.212384	51.00
53.00	05300	ANESTHESIOLOGY	3,804,161	3,417,641	7,221,802	0.038896	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,775,089	20,926,517	24,701,606	0.230135	54.00
56.00	05600	RADIOISOTOPE	2,401,983	20,771,657	23,173,640	0.119641	56.00
57.00	05700	CT SCAN	10,192,479	42,315,458	52,507,937	0.041448	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,398,559	13,472,219	14,870,778	0.083819	58.00
60.00	06000	LABORATORY	21,568,671	54,735,435	76,304,106	0.113340	60.00
65.00	06500	RESPIRATORY THERAPY	5,626,453	1,560,654	7,187,107	0.371417	65.00
66.00	06600	PHYSICAL THERAPY	8,186,595	8,389,744	16,576,339	0.367557	66.00
69.00	06900	ELECTROCARDIOLOGY	5,043,518	12,031,002	17,074,520	0.103088	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,722,451	5,362,568	17,085,019	0.328637	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,169,224	2,641,746	12,810,970	0.315774	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,704,195	10,151,311	30,855,506	0.258302	73.00
76.97	07697	CARDIAC REHABILITATION	3,120	1,766,883	1,770,003	0.483034	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	19,484	2,179,254	2,198,738	0.369397	90.00
91.00	09100	EMERGENCY	4,761,715	21,893,942	26,655,657	0.293226	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	146,594	3,848,636	3,995,230	0.630900	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	167,246,330	255,860,875	423,107,205		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	167,246,330	255,860,875	423,107,205		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet C  
Part I  
Date/Time Prepared:  
8/26/2014 2:09 pm

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140011		Period: From 04/01/2013 To 03/31/2014		Worksheet D Part I Date/Time Prepared: 8/26/2014 2:09 pm		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
Title XVIII Hospital PPS								
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	1,357,401	0	1,357,401	18,985	71.50	30.00	
31.00	INTENSIVE CARE UNIT	236,876		236,876	2,073	114.27	31.00	
41.00	SUBPROVIDER - IRF	585,672	0	585,672	7,105	82.43	41.00	
200.00	Total (Lines 30-199)	2,179,949		2,179,949	28,163		200.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	11,222	802,373					30.00
31.00	INTENSIVE CARE UNIT	1,212	138,495					31.00
41.00	SUBPROVIDER - IRF	5,046	415,942					41.00
200.00	Total (Lines 30-199)	17,480	1,356,810					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140011	Period: From 04/01/2013 To 03/31/2014	Worksheet D Part II Date/Time Prepared: 8/26/2014 2:09 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,751,319	54,726,183	0.032001	12,900,734	412,836	50.00
51.00	05100 RECOVERY ROOM	44,305	3,682,974	0.012030	1,117,892	13,448	51.00
53.00	05300 ANESTHESIOLOGY	48,467	7,221,802	0.006711	1,816,251	12,189	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	906,999	24,701,606	0.036718	2,509,552	92,146	54.00
56.00	05600 RADIOISOTOPE	385,455	23,173,640	0.016633	1,740,789	28,955	56.00
57.00	05700 CT SCAN	352,143	52,507,937	0.006706	7,169,237	48,077	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	405,526	14,870,778	0.027270	848,775	23,146	58.00
60.00	06000 LABORATORY	583,786	76,304,106	0.007651	14,123,669	108,060	60.00
65.00	06500 RESPIRATORY THERAPY	204,066	7,187,107	0.028393	3,519,469	99,928	65.00
66.00	06600 PHYSICAL THERAPY	394,261	16,576,339	0.023785	1,415,643	33,671	66.00
69.00	06900 ELECTROCARDIOLOGY	268,400	17,074,520	0.015719	3,896,106	61,243	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	47,447	17,085,019	0.002777	3,793,239	10,534	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	31,449	12,810,970	0.002455	6,016,575	14,771	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	150,623	30,855,506	0.004882	12,088,078	59,014	73.00
76.97	07697 CARDIAC REHABILITATION	62,680	1,770,003	0.035412	1,072	38	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	7,916	2,198,738	0.003600	18,649	67	90.00
91.00	09100 EMERGENCY	557,575	26,655,657	0.020918	3,014,738	63,062	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	190,186	3,995,230	0.047603	146,594	6,978	92.00
200.00	Total (lines 50-199)	6,392,603	393,398,115		76,137,062	1,088,163	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140011		Period: From 04/01/2013 To 03/31/2014		Worksheet D Part III Date/Time Prepared: 8/26/2014 2:09 pm	
Title XVIII			Hospital			PPS		
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0 30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0 41.00	
200.00		Total (lines 30-199)	0	0	0	0	0 200.00	
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,985	0.00	11,222	0	0 30.00	
31.00	03100	INTENSIVE CARE UNIT	2,073	0.00	1,212	0	0 31.00	
41.00	04100	SUBPROVIDER - IRF	7,105	0.00	5,046	0	0 41.00	
200.00		Total (lines 30-199)	28,163		17,480	0	0 200.00	
Cost Center Description			PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost				
			12.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00			
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00			
41.00	04100	SUBPROVIDER - IRF	0	0	41.00			
200.00		Total (lines 30-199)	0	0	200.00			

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet D  
Part IV  
Date/Time Prepared:  
8/26/2014 2:09 pm

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet D  
Part IV  
Date/Time Prepared:  
8/26/2014 2:09 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	54,726,183	0.000000	0.000000	12,900,734	50.00
51.00	05100 RECOVERY ROOM	0	3,682,974	0.000000	0.000000	1,117,892	51.00
53.00	05300 ANESTHESIOLOGY	0	7,221,802	0.000000	0.000000	1,816,251	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	24,701,606	0.000000	0.000000	2,509,552	54.00
56.00	05600 RADIOISOTOPE	0	23,173,640	0.000000	0.000000	1,740,789	56.00
57.00	05700 CT SCAN	0	52,507,937	0.000000	0.000000	7,169,237	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	14,870,778	0.000000	0.000000	848,775	58.00
60.00	06000 LABORATORY	0	76,304,106	0.000000	0.000000	14,123,669	60.00
65.00	06500 RESPIRATORY THERAPY	0	7,187,107	0.000000	0.000000	3,519,469	65.00
66.00	06600 PHYSICAL THERAPY	0	16,576,339	0.000000	0.000000	1,415,643	66.00
69.00	06900 ELECTROCARDIOLOGY	0	17,074,520	0.000000	0.000000	3,896,106	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17,085,019	0.000000	0.000000	3,793,239	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	12,810,970	0.000000	0.000000	6,016,575	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	30,855,506	0.000000	0.000000	12,088,078	73.00
76.97	07697 CARDIAC REHABILITATION	0	1,770,003	0.000000	0.000000	1,072	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	2,198,738	0.000000	0.000000	18,649	90.00
91.00	09100 EMERGENCY	0	26,655,657	0.000000	0.000000	3,014,738	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	3,995,230	0.000000	0.000000	146,594	92.00
200.00	Total (lines 50-199)	0	393,398,115			76,137,062	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet D  
Part IV  
Date/Time Prepared:  
8/26/2014 2:09 pm

Cost Center Description		Title XVIII			Hospital	PPS	
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	9,620,737	0	0	0 50.00
51.00	05100	RECOVERY ROOM	0	473,605	0	0	0 51.00
53.00	05300	ANESTHESIOLOGY	0	1,146,111	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,300,317	0	0	0 54.00
56.00	05600	RADIOISOTOPE	0	10,505,187	0	0	0 56.00
57.00	05700	CT SCAN	0	14,831,679	0	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	4,261,348	0	0	0 58.00
60.00	06000	LABORATORY	0	3,412,795	0	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	0	689,705	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
69.00	06900	ELECTROCARDIOLOGY	0	5,747,770	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,355,254	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,117,488	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,158,770	0	0	0 73.00
76.97	07697	CARDIAC REHABILITATION	0	865,652	0	0	0 76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	1,268,895	0	0	0 90.00
91.00	09100	EMERGENCY	0	5,645,949	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,694,252	0	0	0 92.00
200.00		Total (lines 50-199)	0	72,095,514	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140011	Period: From 04/01/2013 To 03/31/2014	Worksheet D Part IV Date/Time Prepared: 8/26/2014 2:09 pm
Title XVIII		Hospital	PPS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140011	Period: From 04/01/2013 To 03/31/2014	Worksheet D Part V Date/Time Prepared: 8/26/2014 2:09 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0.214565	9,620,737	0	0	2,064,273 50.00
51.00	05100 RECOVERY ROOM	0.212384	473,605	0	0	100,586 51.00
53.00	05300 ANESTHESIOLOGY	0.038896	1,146,111	0	0	44,579 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.230135	6,300,317	0	0	1,449,923 54.00
56.00	05600 RADIOISOTOPE	0.119641	10,505,187	0	0	1,256,851 56.00
57.00	05700 CT SCAN	0.041448	14,831,679	0	0	614,743 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.083819	4,261,348	0	0	357,182 58.00
60.00	06000 LABORATORY	0.113340	3,412,795	798	0	386,806 60.00
65.00	06500 RESPIRATORY THERAPY	0.371417	689,705	0	0	256,168 65.00
66.00	06600 PHYSICAL THERAPY	0.367557	0	0	0	0 66.00
69.00	06900 ELECTROCARDIOLOGY	0.103088	5,747,770	0	0	592,526 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.328637	1,355,254	0	0	445,387 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.315774	1,117,488	0	0	352,874 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.258302	3,158,770	0	88,302	815,917 73.00
76.97	07697 CARDIAC REHABILITATION	0.483034	865,652	0	0	418,139 76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	0.369397	1,268,895	0	0	468,726 90.00
91.00	09100 EMERGENCY	0.293226	5,645,949	0	0	1,655,539 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.630900	1,694,252	0	0	1,068,904 92.00
200.00	Subtotal (see instructions)		72,095,514	798	88,302	12,349,123 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		72,095,514	798	88,302	12,349,123 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140011	Period: From 04/01/2013 To 03/31/2014	Worksheet D Part V Date/Time Prepared: 8/26/2014 2:09 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000 LABORATORY	90	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	22,809	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Subtotal (see instructions)	90	22,809	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	90	22,809	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140011 Component CCN: 14T011		Period: From 04/01/2013 To 03/31/2014		Worksheet D Part II Date/Time Prepared: 8/26/2014 2:09 pm		
		Title XVIII		Subprovider - IRF		PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,751,319	54,726,183	0.032001	47,676	1,526	50.00
51.00	05100	RECOVERY ROOM	44,305	3,682,974	0.012030	3,225	39	51.00
53.00	05300	ANESTHESIOLOGY	48,467	7,221,802	0.006711	2,808	19	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	906,999	24,701,606	0.036718	148,562	5,455	54.00
56.00	05600	RADIOISOTOPE	385,455	23,173,640	0.016633	22,939	382	56.00
57.00	05700	CT SCAN	352,143	52,507,937	0.006706	160,705	1,078	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	405,526	14,870,778	0.027270	22,820	622	58.00
60.00	06000	LABORATORY	583,786	76,304,106	0.007651	1,181,483	9,040	60.00
65.00	06500	RESPIRATORY THERAPY	204,066	7,187,107	0.028393	375,823	10,671	65.00
66.00	06600	PHYSICAL THERAPY	394,261	16,576,339	0.023785	4,357,469	103,642	66.00
69.00	06900	ELECTROCARDIOLOGY	268,400	17,074,520	0.015719	35,512	558	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	47,447	17,085,019	0.002777	3,060	8	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31,449	12,810,970	0.002455	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	150,623	30,855,506	0.004882	1,548,352	7,559	73.00
76.97	07697	CARDIAC REHABILITATION	62,680	1,770,003	0.035412	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	7,916	2,198,738	0.003600	0	0	90.00
91.00	09100	EMERGENCY	557,575	26,655,657	0.020918	696	15	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,995,230	0.000000	0	0	92.00
200.00		Total (lines 50-199)	6,202,417	393,398,115		7,911,130	140,614	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140011 Component CCN: 14T011	Period: From 04/01/2013 To 03/31/2014	Worksheet D Part IV Date/Time Prepared: 8/26/2014 2:09 pm
Title XVIII		Subprovider - IRF	PPS

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140011 Component CCN: 14T011	Period: From 04/01/2013 To 03/31/2014	Worksheet D Part IV Date/Time Prepared: 8/26/2014 2:09 pm
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient Program Charges	
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 + col. 7)	Ratio of Cost to Charges (col. 6 + col. 7)		
	6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	54,726,183	0.000000	0.000000	47,676	50.00
51.00 05100 RECOVERY ROOM	0	3,682,974	0.000000	0.000000	3,225	51.00
53.00 05300 ANESTHESIOLOGY	0	7,221,802	0.000000	0.000000	2,808	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	24,701,606	0.000000	0.000000	148,562	54.00
56.00 05600 RADIOISOTOPE	0	23,173,640	0.000000	0.000000	22,939	56.00
57.00 05700 CT SCAN	0	52,507,937	0.000000	0.000000	160,705	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	14,870,778	0.000000	0.000000	22,820	58.00
60.00 06000 LABORATORY	0	76,304,106	0.000000	0.000000	1,181,483	60.00
65.00 06500 RESPIRATORY THERAPY	0	7,187,107	0.000000	0.000000	375,823	65.00
66.00 06600 PHYSICAL THERAPY	0	16,576,339	0.000000	0.000000	4,357,469	66.00
69.00 06900 ELECTROCARDIOLOGY	0	17,074,520	0.000000	0.000000	35,512	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17,085,019	0.000000	0.000000	3,060	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	12,810,970	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	30,855,506	0.000000	0.000000	1,548,352	73.00
76.97 07697 CARDIAC REHABILITATION	0	1,770,003	0.000000	0.000000	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	2,198,738	0.000000	0.000000	0	90.00
91.00 09100 EMERGENCY	0	26,655,657	0.000000	0.000000	696	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	3,995,230	0.000000	0.000000	0	92.00
200.00 Total (lines 50-199)	0	393,398,115			7,911,130	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140011 Component CCN: 14T011	Period: From 04/01/2013 To 03/31/2014	Worksheet D Part IV Date/Time Prepared: 8/26/2014 2:09 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140011 Component CCN: 14T011	Period: From 04/01/2013 To 03/31/2014	Worksheet D Part IV Date/Time Prepared: 8/26/2014 2:09 pm
	Title XVIII	Subprovider - IRF	PPS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140011 Component CCN: 14T011	Period: From 04/01/2013 To 03/31/2014	Worksheet D Part V Date/Time Prepared: 8/26/2014 2:09 pm
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			PPS Services (see inst.)	PPS Services (see inst.)
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0.214565	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.212384	0	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.038896	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.230135	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0.119641	0	0	0	56.00
57.00	05700 CT SCAN	0.041448	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.083819	0	0	0	58.00
60.00	06000 LABORATORY	0.113340	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.371417	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.367557	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.103088	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.328637	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.315774	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.258302	0	0	1,357	73.00
76.97	07697 CARDIAC REHABILITATION	0.483034	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	0.369397	0	0	0	90.00
91.00	09100 EMERGENCY	0.293226	0	0	992	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.630900	0	0	0	92.00
200.00	Subtotal (see instructions)		0	0	2,349	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	2,349	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140011	Period: From 04/01/2013	Worksheet D Part V Date/Time Prepared: 8/26/2014 2:09 pm
	Component CCN: 14T011	To 03/31/2014	
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00 06000 LABORATORY	0	0		60.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	351		73.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	291		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00 Subtotal (see instructions)	0	642		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	642		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140011 Component CCN: 14T011	Period: From 04/01/2013 To 03/31/2014	Worksheet D Part V Date/Time Prepared: 8/26/2014 2:09 pm
	Title XIX	Subprovider - IRF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0.214565	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.212384	0	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.038896	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.230135	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0.119641	0	0	0	56.00
57.00	05700 CT SCAN	0.041448	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.083819	0	0	0	58.00
60.00	06000 LABORATORY	0.113340	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.371417	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.367557	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.103088	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.328637	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.315774	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.258302	0	0	0	73.00
76.97	07697 CARDIAC REHABILITATION	0.483034	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	0.369397	0	0	0	90.00
91.00	09100 EMERGENCY	0.293226	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.630900	0	0	0	92.00
200.00	Subtotal (see instructions)		0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140011	Period:	Worksheet D
	Component CCN: 14T011	From 04/01/2013 To 03/31/2014	Part V Date/Time Prepared: 8/26/2014 2:09 pm
	Title XIX	Subprovider - IRF	Cost

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00 05600 RADIOISOTOPE	0	0	56.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00 06000 LABORATORY	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00 09000 CLINIC	0	0	90.00
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00 Subtotal (see instructions)	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140011	Period: From 04/01/2013 To 03/31/2014	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 8/26/2014 2:09 pm
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		18,985	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		18,985	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)		16,325	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)		11,222	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		17,989,935	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)		17,989,935	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		17,989,935	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		947.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		10,633,855	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)		10,633,855	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140011	Period: From 04/01/2013 To 03/31/2014	Worksheet D-1 Date/Time Prepared: 8/26/2014 2:09 pm		
Cost Center Description			Title XVIII		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	4,001,284	2,073	1,930.19	1,212	2,339,390		
44.00	CORONARY CARE UNIT					43.00	
45.00	BURN INTENSIVE CARE UNIT					44.00	
46.00	SURGICAL INTENSIVE CARE UNIT					45.00	
47.00	OTHER SPECIAL CARE (SPECIFY)					46.00	
Cost Center Description							
					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					15,335,014	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					28,308,259	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)					940,868	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,088,163	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,029,031	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					26,279,228	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)					2,660	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					947.59	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,520,589	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140011		Period: From 04/01/2013 To 03/31/2014		Worksheet D-1 Date/Time Prepared: 8/26/2014 2:09 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,357,401	17,989,935	0.075453	2,520,589	190,186	90.00
91.00	Nursing School cost	0	17,989,935	0.000000	2,520,589	0	91.00
92.00	Allied health cost	0	17,989,935	0.000000	2,520,589	0	92.00
93.00	All other Medical Education	0	17,989,935	0.000000	2,520,589	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140011 Component CCN: 14T011	Period: From 04/01/2013 To 03/31/2014	Worksheet D-1 Date/Time Prepared: 8/26/2014 2:09 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,105	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,105	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		7,105	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		5,046	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,885,472	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)		6,885,472	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		6,885,472	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		969.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,890,079	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		4,890,079	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140011	Period: From 04/01/2013 To 03/31/2014	Worksheet D-1		
		Component CCN: 14T011		Date/Time Prepared: 8/26/2014 2:09 pm		
		Title XVIII	Subprovider - IRF	PPS		
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	0	0	0.00	0	0	43.00
44.00	INTENSIVE CARE UNIT					44.00
45.00	CORONARY CARE UNIT					45.00
46.00	BURN INTENSIVE CARE UNIT					46.00
47.00	SURGICAL INTENSIVE CARE UNIT					47.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				2,336,980	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				7,227,059	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)				415,942	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				140,614	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				556,556	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				6,670,503	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges				0	54.00
55.00	Target amount per discharge				0.00	55.00
56.00	Target amount (line 54 x line 55)				0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0	57.00
58.00	Bonus payment (see instructions)				0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0	61.00
62.00	Relief payment (see instructions)				0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)				0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140011 Component CCN: 14T011		Period: From 04/01/2013 To 03/31/2014		Worksheet D-1 Date/Time Prepared: 8/26/2014 2:09 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	585,672	6,885,472	0.085059	0	0	90.00
91.00	Nursing School cost	0	6,885,472	0.000000	0	0	91.00
92.00	Allied health cost	0	6,885,472	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,885,472	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140011	Period: From 04/01/2013 To 03/31/2014	Worksheet D-3 Date/Time Prepared: 8/26/2014 2:09 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		9,536,754	30.00
31.00	03100	INTENSIVE CARE UNIT		1,776,301	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.215843	12,900,734	2,784,533 50.00
51.00	05100	RECOVERY ROOM	0.212384	1,117,892	237,422 51.00
53.00	05300	ANESTHESIOLOGY	0.038896	1,816,251	70,645 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.230135	2,509,552	577,536 54.00
56.00	05600	RADIOISOTOPE	0.119641	1,740,789	208,270 56.00
57.00	05700	CT SCAN	0.041448	7,169,237	297,151 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.083819	848,775	71,143 58.00
60.00	06000	LABORATORY	0.113458	14,123,669	1,602,443 60.00
65.00	06500	RESPIRATORY THERAPY	0.372266	3,519,469	1,310,179 65.00
66.00	06600	PHYSICAL THERAPY	0.367557	1,415,643	520,329 66.00
69.00	06900	ELECTROCARDIOLOGY	0.103146	3,896,106	401,868 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.328637	3,793,239	1,246,599 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.315774	6,016,575	1,899,878 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.258302	12,088,078	3,122,375 73.00
76.97	07697	CARDIAC REHABILITATION	0.483034	1,072	518 76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.370045	18,649	6,901 90.00
91.00	09100	EMERGENCY	0.293471	3,014,738	884,738 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.630900	146,594	92,486 92.00
200.00		Total (sum of lines 50-94 and 96-98)		76,137,062	15,335,014 200.00
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)		76,137,062	15,335,014 202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140011 Component CCN: 14T011	Period: From 04/01/2013 To 03/31/2014	Worksheet D-3 Date/Time Prepared: 8/26/2014 2:09 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
41.00	04100 SUBPROVIDER - IRF		8,411,252	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.215843	47,676	50.00
51.00	05100 RECOVERY ROOM	0.212384	3,225	51.00
53.00	05300 ANESTHESIOLOGY	0.038896	2,808	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.230135	148,562	54.00
56.00	05600 RADIOISOTOPE	0.119641	22,939	56.00
57.00	05700 CT SCAN	0.041448	160,705	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.083819	22,820	58.00
60.00	06000 LABORATORY	0.113458	1,181,483	60.00
65.00	06500 RESPIRATORY THERAPY	0.372266	375,823	65.00
66.00	06600 PHYSICAL THERAPY	0.367557	4,357,469	66.00
69.00	06900 ELECTROCARDIOLOGY	0.103146	35,512	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.328637	3,060	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.315774	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.258302	1,548,352	73.00
76.97	07697 CARDIAC REHABILITATION	0.483034	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.370045	0	90.00
91.00	09100 EMERGENCY	0.293471	696	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.630900	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		7,911,130	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net Charges (line 200 minus line 201)		7,911,130	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140011	Period: From 04/01/2013 To 03/31/2014	Worksheet E Part A Date/Time Prepared: 8/26/2014 2:09 pm	
		Title XVIII	Hospital		PPS
		0	before 1/1	on/after 1/1	2.00
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER PPS</b>					
1.00	DRG Amounts Other than Outlier Payments		0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013 (see instructions)		10,054,647		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		10,633,263		1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI (see instructions)		0		1.03
2.00	Outlier payments for discharges. (see instructions)		416,672		2.00
2.01	Outlier reconciliation amount		0		2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0		2.02
3.00	Managed Care Simulated Payments		0		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		77.71		4.00
<b>Indirect Medical Education Adjustment</b>					
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
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)		0		28.00
29.00	Total IME payment ( sum of lines 22 and 28)		0		29.00
<b>Disproportionate Share Adjustment</b>					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.86		30.00
31.00	Percentage of Medicaid patient days (see instructions)		11.31		31.00
32.00	Sum of lines 30 and 31		16.17		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140011	Period: From 04/01/2013 To 03/31/2014	Worksheet E Part A Date/Time Prepared: 8/26/2014 2:09 pm	
		Title XVIII	Hospital	PPS	
		0	before 1/1	on/after 1/1	2.00
33.00	Allowable disproportionate share percentage (see instructions)		3.26	1.01	33.00
34.00	Disproportionate share adjustment (see instructions)		414,442		34.00
		0	Prior to October 1	On/After October 1	
		0	1.00	1.01	2.00
<b>Uncompensated Care Adjustment</b>					
35.00	Total uncompensated care amount (see instructions)				9,046,380 35.00
35.01	Factor 3 (see instructions)				0.000090558 35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)				819,221 35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)				408,488 35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		408,488		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0		46.00
47.00	Subtotal (see instructions)		21,927,512		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		24,884,984		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		24,145,616		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		1,665,919		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)		25,811,535		59.00
60.00	Primary payer payments		32,801		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		25,778,734		61.00
62.00	Deductibles billed to program beneficiaries		2,415,776		62.00
63.00	Coinurance billed to program beneficiaries		123,528		63.00
64.00	Allowable bad debts (see instructions)		677,478		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		440,361		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		603,288		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		23,679,791		67.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140011	Period: From 04/01/2013 To 03/31/2014	Worksheet E Part A Date/Time Prepared: 8/26/2014 2:09 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	1.01	On/After October 1 2.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0		68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.92	Bundled Model 1 discount amount		0		70.92
70.93	HVBP incentive payment (see instructions)		25,737		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		-96,575		70.94
70.95	Recovery of Accelerated Depreciation		0		70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		23,608,953		71.00
71.01	Sequestration adjustment (see instructions)		472,179		71.01
72.00	Interim payments		22,408,854		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) line 71 minus lines 71.01, 72 and 73		727,920		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		23,114		75.00
<b>TO BE COMPLETED BY CONTRACTOR</b>					
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the Time Value of Money		0.00		94.00
95.00	Time Value of Money for operating expenses(see instructions)		0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)		0		96.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140011		Period: From 04/01/2013 To 03/31/2014		Worksheet DSH	
		Title XVIII		Hospital		Date/Time Prepared: 8/26/2014 2:09 pm	
		PPS					
		Original .mcrcx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
<b>CALCULATION OF THE DSH PAYMENT PERCENTAGE</b>							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	4.86	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	11.31	0.00			11.31	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	16.17	0.00			11.31	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	MDH				MDH	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	77.71	0.00			77.71	5.00
6.00	Disproportionate Share Payment Percentage (transfer to Worksheet E, Part A, line 33)	3.26	0.00			0.00	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				No	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No				No	9.00
10.00	S-2, Line 45	No				No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00		0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	Yes				Yes	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	4.12	0.00	0.00		0.00	14.00
<b>CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS</b>							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	1,822	0			1,822	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	107	0			107	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	6	0			6	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	145	0			145	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	2,080	0			2,080	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	18,398	0			18,398	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)	18,398	0			18,398	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	11.31	0.00			11.31	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140011		Period: From 04/01/2013 To 03/31/2014		Worksheet DSH Date/Time Prepared: 8/26/2014 2:09 pm	
		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
<b>CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE</b>							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	False	0.00		0.00	False	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	True	3.26		0.00	True	29.00
30.00	Line 28 or 29 as applicable		3.26		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		0.00		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
<b>DETERMINATION OF PROVIDER TYPE</b>							
32.00	Does the hospital qualify under the Pickle amendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	True				True	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Rural				Rural	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140011	Period: From 04/01/2013 To 03/31/2014	Worksheet DSH Date/Time Prepared: 8/26/2014 2:09 pm
		Title XVIII	Hospital	PPS

		Revised		
		Percentage		
		6.00		
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE				
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	0.00		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	4.90		29.00
30.00	Line 28 or 29 as applicable	4.90		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	0.00		31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140011	Period: From 04/01/2013 To 03/31/2014	Worksheet E Part B Date/Time Prepared: 8/26/2014 2:09 pm
		Title XVII	Hospital	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		22,899	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		12,349,123	2.00
3.00	PPS payments		9,588,336	3.00
4.00	Outlier payment (see instructions)		44,018	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.804	5.00
6.00	Line 2 times line 5		9,928,695	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		97.02	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		22,899	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		89,100	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)		89,100	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		89,100	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		66,201	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)		22,899	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		9,632,354	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		123,954	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,205,613	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		7,325,686	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		7,325,686	30.00
31.00	Primary payer payments		413	31.00
32.00	Subtotal (line 30 minus line 31)		7,325,273	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		614,472	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		399,407	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		554,743	36.00
37.00	Subtotal (see instructions)		7,724,680	37.00
38.00	MSP-LCC reconciliation amount from PS&R		190	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		7,724,490	40.00
40.01	Sequestration adjustment (see instructions)		154,490	40.01
41.00	Interim payments		7,486,340	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		83,660	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00
			Overrides	
			1.00	
<b>WORKSHEET OVERRIDE VALUES</b>				
112.00	Override of Ancillary service charges (line 12)		0	112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140011	Period: From 04/01/2013 To 03/31/2014	Worksheet E Part B Date/Time Prepared: 8/26/2014 2:09 pm
		Component CCN: 14T011	Title XVIII	Subprovider - IRF
		PPS		
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		642	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		829	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.804	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		642	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		2,349	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)		2,349	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		2,349	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,707	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)		642	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)		829	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		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)		1,471	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)		1,471	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,471	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		1,471	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,471	40.00
40.01	Sequestration adjustment (see instructions)		29	40.01
41.00	Interim payments		813	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		629	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00
		Overrides		
		1.00		
<b>WORKSHEET OVERRIDE VALUES</b>				
112.00	Override of Ancillary service charges (line 12)		0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet E-1  
Part I  
Date/Time Prepared:  
8/26/2014 2:09 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		22,408,854		7,486,340	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)		22,408,854		7,486,340	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		727,920		83,660	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		23,136,774		7,570,000	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140011  
Component CCN: 14T011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet E-1  
Part I  
Date/Time Prepared:  
8/26/2014 2:09 pm

Title XVIII

Subprovider -  
IRF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					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		7,266,203		813	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)		7,266,203		813	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		193,112		629	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		7,459,315		1,442	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet E-1  
Part II  
Date/Time Prepared:  
8/26/2014 2:09 pm

		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			4,968 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			12,434 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			601 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			18,398 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			423,107,205 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			14,168,026 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			2,025,865 8.00
9.00	Sequestration adjustment amount (see instructions)			0 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			2,025,865 10.00
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			1,984,651 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			41,214 32.00
				Overrides
				1.00
<b>CONTRACTOR OVERRIDES</b>				
108.00	Override of HIT payment			0 108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140011 Component CCN: 14T011	Period: From 04/01/2013 To 03/31/2014	Worksheet E-3 Part III Date/Time Prepared: 8/26/2014 2:09 pm
		Title XVIIII	Subprovider - IRF	PPS
		Prior to 10/01	On/After 10/01	
		1.00	1.01	
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)	3,462,400	3,484,821	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0412		2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	288,072	197,241	3.00
4.00	Outlier Payments	281,188		4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00		5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00		5.01
6.00	New Teaching program adjustment. (see instructions)	0.00		6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program". (see inst.)	0.00		7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program". (see inst.)	0.00		8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00		9.00
10.00	Average Daily Census (see instructions)	19.465753		10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	0	12.00
13.00	Total PPS Payment (see instructions)	7,713,722		13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0		14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			15.00
16.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0		16.00
17.00	Subtotal (see instructions)	7,713,722		17.00
18.00	Primary payer payments	12,008		18.00
19.00	Subtotal (line 17 less line 18).	7,701,714		19.00
20.00	Deductibles	61,792		20.00
21.00	Subtotal (line 19 minus line 20)	7,639,922		21.00
22.00	Coinurance	28,376		22.00
23.00	Subtotal (line 21 minus line 22)	7,611,546		23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0		24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0		25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		26.00
27.00	Subtotal (sum of lines 23 and 25)	7,611,546		27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0		28.00
29.00	Other pass through costs (see instructions)	0		29.00
30.00	Outlier payments reconciliation	0		30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		31.00
31.99	Recovery of Accelerated Depreciation	0		31.99
32.00	Total amount payable to the provider (see instructions)	7,611,546		32.00
32.01	Sequestration adjustment (see instructions)	152,231		32.01
33.00	Interim payments	7,266,203		33.00
34.00	Tentative settlement (for contractor use only)	0		34.00
35.00	Balance due provider/program line 32 minus lines 32.01, 33 and 34	193,112		35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0		36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4	281,188		50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0		51.00
52.00	The rate used to calculate the Time Value of Money	0.00		52.00
53.00	Time Value of Money (see instructions)	0		53.00

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

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet G

Date/Time Prepared:  
8/26/2014 2:09 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	1,607,807	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	752,249	0	0	0	3.00
4.00	Accounts receivable	79,671,876	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-56,364,365	0	0	0	6.00
7.00	Inventory	2,084,552	0	0	0	7.00
8.00	Prepaid expenses	293,717	0	0	0	8.00
9.00	Other current assets	1,409,412	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)	29,455,248	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	3,782,103	0	0	0	12.00
13.00	Land improvements	4,200,209	0	0	0	13.00
14.00	Accumulated depreciation	-2,177,458	0	0	0	14.00
15.00	Buildings	66,465,139	0	0	0	15.00
16.00	Accumulated depreciation	-30,156,159	0	0	0	16.00
17.00	Leasehold improvements	4,220	0	0	0	17.00
18.00	Accumulated depreciation	-1,008	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	252,929	0	0	0	21.00
22.00	Accumulated depreciation	-164,533	0	0	0	22.00
23.00	Major movable equipment	23,883,415	0	0	0	23.00
24.00	Accumulated depreciation	-14,326,818	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	2,175,140	0	0	0	27.00
28.00	Accumulated depreciation	-2,008,413	0	0	0	28.00
29.00	Minor equipment-nondepreciable	337,086	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	52,265,852	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	84,270,661	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	740,583	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	85,011,244	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	166,732,344	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	3,769,574	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,597,958	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,613,746	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	2,864,863	0	0	0	43.00
44.00	Other current liabilities	711,826	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	13,557,967	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	44,890,351	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,469,347	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	46,359,698	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	59,917,665	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	106,814,679				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)	106,814,679	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	166,732,344	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet G-1

Date/Time Prepared:  
8/26/2014 2:09 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		99,306,610		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		7,508,066			2.00
3.00	Total (sum of line 1 and line 2)		106,814,676		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00	ROUNDING	3		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)		3		0	10.00
11.00	Subtotal (line 3 plus line 10)		106,814,679		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)		106,814,679		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	ROUNDING		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: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
8/26/2014 2:09 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	19,150,602		19,150,602	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	12,240,712		12,240,712	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	31,391,314		31,391,314	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	2,696,360		2,696,360	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	2,696,360		2,696,360	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	34,087,674		34,087,674	17.00
18.00	Ancillary services	137,803,528	257,145,295	394,948,823	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	171,891,202	257,145,295	429,036,497	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		98,911,687		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)		98,911,687		43.00

## STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140011

Period:  
From 04/01/2013  
To 03/31/2014

Worksheet G-3

Date/Time Prepared:  
8/26/2014 2:09 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	429,036,497	1.00
2.00	Less contractual allowances and discounts on patients' accounts	303,905,483	2.00
3.00	Net patient revenues (line 1 minus line 2)	125,131,014	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	98,911,687	4.00
5.00	Net income from service to patients (line 3 minus line 4)	26,219,327	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	9,746,984	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	5,010	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	386,292	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	875	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	55,703	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	279,869	22.00
23.00	Governmental appropriations	2,576,326	23.00
24.00	MISCELLANEOUS	14,739	24.00
25.00	Total other income (sum of lines 6-24)	13,065,798	25.00
26.00	Total (line 5 plus line 25)	39,285,125	26.00
27.00	CORP ALLOC/CONTRIBUTIONS	31,777,059	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	31,777,059	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	7,508,066	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140011	Period: From 04/01/2013 To 03/31/2014	Worksheet L Parts I-III Date/Time Prepared: 8/26/2014 2:09 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		1,625,200	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		40,719	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		50.41	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 (multiply line 5 by the sum of lines 1 and 1.01)		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 (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		0	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		1,665,919	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
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
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
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