

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: 140043	Period: From 05/01/2013 To 04/30/2014	Worksheet S Parts I-III Date/Time Prepared: 9/26/2014 5:35 pm
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<b>PART I - COST REPORT STATUS</b>			
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: 9/26/2014	Time: 5:35 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 CGH MEDICAL CENTER ( 140043 ) for the cost reporting period beginning 05/01/2013 and ending 04/30/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

\_\_\_\_\_ Title

\_\_\_\_\_ Date

Cost Center Description	Title V 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	39,591	41,391	837,279	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	-86		0	9.00
200.00 Total	0	39,591	41,305	837,279	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: 140043		Period: From 05/01/2013 To 04/30/2014		Worksheet S-2 Part I Date/Time Prepared: 9/26/2014 5:19 pm					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 100 EAST LEFEVRE ROAD		PO Box:						1.00		
2.00	City: STERLING		State: IL		Zip Code: 61081-1279		County: WHITESIDE		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		CGH MEDICAL CENTER	140043	99914	1	07/01/1966	N	P	N	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF		CGH MEDICAL CENTER	140043	99914		01/13/2004	N	P	N	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		CGH HOME NURSING	147562	99914		05/05/1994	N	P	N	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)					05/01/2013	04/30/2014		20.00		
21.00	Type of Control (see instructions)					12		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.		2,406	561	6	5	7	0	24.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.		0	0	0	0	0		25.00		
						Urban/Rural	S	Date of Geogr			
						1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					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			

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		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	1				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.	05/01/2013	04/30/2014			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.	N				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	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			
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)			0.00	62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)			0.00	62.01		
<u>Teaching Hospitals that Claim Residents in Non-Provider Settings</u>							
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)			N	63.00		
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
<u>Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.</u>							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
			Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
<u>Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010</u>							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	

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

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		V	XIX			
		1.00	2.00			
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00	
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	
		1.00	2.00	3.00		
<b>Miscellaneous Cost Reporting Information</b>						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		Y			
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		N			
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1			
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	1,073,681	144,888	0		
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N			
119.00	DO NOT USE THIS LINE					
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N		
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N			
<b>Transplant Center Information</b>						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					
<b>All Providers</b>						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		N			

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

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

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

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	N	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						0.00	166.00

		1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	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)		0168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.50	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	09/30/2013	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140043	Period: From 05/01/2013 To 04/30/2014	Worksheet S-2 Part II Date/Time Prepared: 9/26/2014 5:19 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	07/02/2014	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: 140043	Period: From 05/01/2013 To 04/30/2014	Worksheet S-2 Part II Date/Time Prepared: 9/26/2014 5:19 pm	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
		Y/N	Date		
		1.00	2.00		
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
		1.00	2.00		
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN		WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544		KWELLEN@BKD.COM	43.00

		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)	07/02/2014	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.	DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet S-3  
Part I  
Date/Time Prepared:  
9/26/2014 5:19 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	85	31,025	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)		85	31,025	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	43.00				0	13.00
14.00 Total (see instructions)		93	33,945	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	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)		93				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: 140043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet S-3  
Part I  
Date/Time Prepared:  
9/26/2014 5:19 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)	8,344	1,599	14,490			1.00
2.00 HMO and other (see instructions)	179	572				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	8,344	1,599	14,490			7.00
8.00 INTENSIVE CARE UNIT	1,016	118	1,501			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		565	984			13.00
14.00 Total (see instructions)	9,360	2,282	16,975	0.00	1,105.01	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	5,232	0	7,760	0.00	15.39	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	1,120.40	27.00
28.00 Observation Bed Days		0	2,874			28.00
29.00 Ambulance Trips	2,261					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	131	179			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: 140043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet S-3  
Part I  
Date/Time Prepared:  
9/26/2014 5:19 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
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	2,535	751	5,155	1.00
2.00 HMO and other (see instructions)			51			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	2,535	751	5,155	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					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: 140043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet S-3  
Part II  
Date/Time Prepared:  
9/26/2014 5:19 pm

	Worksheet A Line Number	Amount Reported	Reclassification 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 II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	75,816,537	0	75,816,537	2,327,245.30	32.58
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		2,037,354	0	2,037,354	16,269.50	125.23
4.00	Physician-Part A - Administrative		135,162	0	135,162	901.08	150.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		22,175,651	0	22,175,651	126,219.00	175.69
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)		2,827,467	335,167	3,162,634	129,581.26	24.41
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract labor (see instructions)		306,527	0	306,527	7,574.45	40.47
12.00	Contract management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00
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)		24,182,030	0	24,182,030		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		1,561,466	0	1,561,466		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		397,794	0	397,794		
22.00	Physician Part A - Administrative		28,979	0	28,979		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		3,728,139	0	3,728,139		
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	389,894	0	389,894	12,851.47	30.34
27.00	Administrative & General	5.00	11,075,528	211,301	11,286,829	411,307.48	27.44
28.00	Administrative & General under contract (see inst.)		98,695	0	98,695	366.35	269.40
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	1,008,803	0	1,008,803	43,720.54	23.07
31.00	Laundry & Linen Service	8.00	277,128	0	277,128	21,821.30	12.70
32.00	Housekeeping	9.00	895,516	0	895,516	71,307.54	12.56
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	865,495	-631,470	234,025	16,644.61	14.06
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	631,470	631,470	44,912.00	14.06
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	1,083,397	-276,128	807,269	18,563.03	43.49
39.00	Central Services and Supply	14.00	335,344	0	335,344	17,103.88	19.61
40.00	Pharmacy	15.00	883,512	0	883,512	27,569.40	32.05
41.00	Medical Records & Medical Records Library	16.00	1,677,063	0	1,677,063	85,351.47	19.65

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet S-3  
Part II  
Date/Time Prepared:  
9/26/2014 5:19 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: 140043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet S-3  
Part III  
Date/Time Prepared:  
9/26/2014 5:19 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	51,702,227	0	51,702,227	2,185,123.15	23.66	1.00
2.00	Excluded area salaries (see instructions)	2,827,467	335,167	3,162,634	129,581.26	24.41	2.00
3.00	Subtotal salaries (line 1 minus line 2)	48,874,760	-335,167	48,539,593	2,055,541.89	23.61	3.00
4.00	Subtotal other wages & related costs (see inst.)	306,527	0	306,527	7,574.45	40.47	4.00
5.00	Subtotal wage-related costs (see inst.)	24,211,009	0	24,211,009	0.00	49.88	5.00
6.00	Total (sum of lines 3 thru 5)	73,392,296	-335,167	73,057,129	2,063,116.34	35.41	6.00
7.00	Total overhead cost (see instructions)	18,590,375	-64,827	18,525,548	771,519.07	24.01	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 140043	Period: From 05/01/2013 To 04/30/2014	Worksheet S-3 Part IV Date/Time Prepared: 9/26/2014 5:19 pm
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		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	2,499,732	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)	4,306,077	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
5.00	401K/TSA Plan Administration Fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
<b>HEALTH AND INSURANCE COST</b>			
8.00	Health Insurance (Purchased or Self Funded)	17,968,853	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	99,206	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	145,312	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	3,529,798	17.00
18.00	Medicare Taxes - Employers Portion Only	1,060,009	18.00
19.00	Unemployment Insurance	69,438	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))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	219,984	23.00
24.00	<b>Total Wage Related cost (Sum of lines 1 -23)</b>	<b>29,898,409</b>	<b>24.00</b>
<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: 140043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet S-3  
Part V  
Date/Time Prepared:  
9/26/2014 5:19 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	312,392	0	1.00
2.00	Hospital	306,527	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	5,865	0	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	0	0	17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 140043 Component CCN: 147562		Period: From 05/01/2013 To 04/30/2014		Worksheet S-4 Date/Time Prepared: 9/26/2014 5:19 pm	
				Home Health Agency I		PPS	
				1.00			
0.00	County			WHITESIDE		0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	376	0	1,575	1,951	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	448.00	41.00	185.00	674.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			1.14	0.00	1.14	6.00
7.00	Nursing Supervisor			11.54	0.00	11.54	7.00
8.00	Physical Therapy Service			1.72	0.00	1.72	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.03	0.03	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.05	0.00	0.05	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.94	0.00	0.94	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99914			20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	3,251	244	265	157	3,917	21.00
22.00	Skilled Nursing Visit Charges	541,866	43,920	34,588	28,731	649,105	22.00
23.00	Physical Therapy Visits	888	1	26	15	930	23.00
24.00	Physical Therapy Visit Charges	155,400	175	4,375	2,625	162,575	24.00
25.00	Occupational Therapy Visits	68	0	0	0	68	25.00
26.00	Occupational Therapy Visit Charges	11,900	0	0	0	11,900	26.00
27.00	Speech Pathology Visits	61	0	0	0	61	27.00
28.00	Speech Pathology Visit Charges	10,675	0	0	0	10,675	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	224	18	10	4	256	31.00
32.00	Home Health Aide Visit Charges	17,920	1,440	80	320	19,760	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,492	263	301	176	5,232	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	737,761	45,535	39,043	31,676	854,015	35.00
36.00	Total Number of Episodes (standard/non outlier)	391		77	14	482	36.00
37.00	Total Number of Outlier Episodes		8		1	9	37.00
38.00	Total Non-Routine Medical Supply Charges	6,540	981	717	479	8,717	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 140043	Period: From 05/01/2013 To 04/30/2014	Worksheet S-10 Date/Time Prepared: 9/26/2014 5:19 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)			0.243285	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			6,806,356	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			5,425,911	5.00	
6.00	Medicaid charges			62,935,444	6.00	
7.00	Medicaid cost (line 1 times line 6)			15,311,249	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)			3,078,982	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone SCHIP			74,902	9.00	
10.00	Stand-alone SCHIP charges			594,886	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)			144,727	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)			69,825	12.00	
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00	
Uncompensated care (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			3,148,807	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			10,598,174	1,351,047	11,949,221
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)			2,578,377	328,689	2,907,066
22.00	Partial payment by patients approved for charity care			0	0	0
23.00	Cost of charity care (line 21 minus line 22)			2,578,377	328,689	2,907,066
				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)					13,162,157
27.00	Medicare bad debts for the entire hospital complex (see instructions)					769,323
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)					12,392,834
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)					3,014,991
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)					5,922,057
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)					9,070,864

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet A  
Date/Time Prepared:  
9/26/2014 5:19 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	CAP REL COSTS-BLDG & FIXT		9,544,834	9,544,834	-3,846,024	5,698,810	1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		0	0	6,308,175	6,308,175	2.00
3.00 00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	389,894	30,030,744	30,420,638	219,364	30,640,002	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	11,075,528	9,457,305	20,532,833	490,602	21,023,435	5.00
7.00 00700	OPERATION OF PLANT	1,008,803	2,252,928	3,261,731	194,090	3,455,821	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	277,128	118,970	396,098	0	396,098	8.00
9.00 00900	HOUSEKEEPING	895,516	637,352	1,532,868	12,201	1,545,069	9.00
10.00 01000	DIETARY	865,495	914,742	1,780,237	-1,298,684	481,553	10.00
11.00 01100	CAFETERIA	0	0	0	1,298,684	1,298,684	11.00
13.00 01300	NURSING ADMINISTRATION	1,083,397	145,803	1,229,200	-278,369	950,831	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	335,344	299,384	634,728	-211,473	423,255	14.00
15.00 01500	PHARMACY	883,512	3,861,082	4,744,594	-3,572,725	1,171,869	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,677,063	1,027,841	2,704,904	0	2,704,904	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	10,129,015	1,132,861	11,261,876	-803,175	10,458,701	30.00
31.00 03100	INTENSIVE CARE UNIT	2,028,361	177,442	2,205,803	-786,134	1,419,669	31.00
43.00 04300	NURSERY	0	0	0	463,421	463,421	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	1,180,077	4,739,616	5,919,693	-4,480,791	1,438,902	50.00
51.00 05100	RECOVERY ROOM	845,750	171,597	1,017,347	-158,425	858,922	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	836,277	836,277	52.00
53.00 05300	ANESTHESIOLOGY	2,037,354	493,776	2,531,130	-395,629	2,135,501	53.00
53.01 05301	PAIN MANAGEMENT	115,394	43,012	158,406	-39,842	118,564	53.01
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,150,146	1,430,233	2,580,379	181,791	2,762,170	54.00
54.01 05401	ULTRASOUND	387,181	438,312	825,493	50,306	875,799	54.01
56.00 05600	RADIOISOTOPE	246,362	1,009,938	1,256,300	-875,780	380,520	56.00
57.00 05700	CT SCAN	528,372	1,665,045	2,193,417	-42,851	2,150,566	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	286,362	692,359	978,721	-6,925	971,796	58.00
59.00 05900	CARDIAC CATHETERIZATION	771,660	2,677,695	3,449,355	-2,441,734	1,007,621	59.00
60.00 06000	LABORATORY	2,755,606	3,953,985	6,709,591	-1,579,815	5,129,776	60.00
65.00 06500	RESPIRATORY THERAPY	802,865	266,628	1,069,493	-150,210	919,283	65.00
66.00 06600	PHYSICAL THERAPY	276,813	16,033	292,846	-6,563	286,283	66.00
67.00 06700	OCCUPATIONAL THERAPY	66,506	3,433	69,939	-3,238	66,701	67.00
68.00 06800	SPEECH PATHOLOGY	84,113	3,729	87,842	0	87,842	68.00
69.00 06900	ELECTROCARDIOLOGY	797,877	120,784	918,661	-34,077	884,584	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	171,421	45,697	217,118	-14,461	202,657	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	12,890,203	12,890,203	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	11,902,113	11,902,113	73.00
74.00 07400	RENAL DIALYSIS	0	80,193	80,193	-644	79,549	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01 07501	GI LAB	897,990	600,062	1,498,052	-505,490	992,562	75.01
76.00 03020	DIABETIC EDUCATION	384	0	384	37,786	38,170	76.00
76.01 03021	WOUND CARE	616,374	447,784	1,064,158	-119,952	944,206	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000	CLINIC	25,643,969	10,986,030	36,629,999	-10,280,914	26,349,085	90.00
91.00 09100	EMERGENCY	2,677,438	4,740,541	7,417,979	-419,072	6,998,907	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00 09500	AMBULANCE SERVICES	1,481,292	265,175	1,746,467	-122,000	1,624,467	95.00
98.00 05950	HOME INFUSION	52,901	163,048	215,949	-33,290	182,659	98.00
101.00 10100	HOME HEALTH AGENCY	989,341	180,765	1,170,106	-94,643	1,075,463	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00 11300	INTEREST EXPENSE		797,302	797,302	-797,302	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	75,512,604	95,634,060	171,146,664	1,484,781	172,631,445	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,721	32,304	45,025	0	45,025	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	298,539	2,070,838	2,369,377	-1,834,655	534,722	192.00
194.00 07950	COMMUNITY SERVICE	-7,327	2,774	-4,553	349,874	345,321	194.00
200.00	TOTAL (SUM OF LINES 118-199)	75,816,537	97,739,976	173,556,513	0	173,556,513	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet A  
Date/Time Prepared:  
9/26/2014 5:19 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	-797,302	4,901,508	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-5,638	6,302,537	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,603,313	28,036,689	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,584,978	18,438,457	5.00
7.00	00700	OPERATION OF PLANT	-10,949	3,444,872	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	396,098	8.00
9.00	00900	HOUSEKEEPING	-387	1,544,682	9.00
10.00	01000	DIETARY	-6,872	474,681	10.00
11.00	01100	CAFETERIA	-743,321	555,363	11.00
13.00	01300	NURSING ADMINISTRATION	-2,000	948,831	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-3,861	419,394	14.00
15.00	01500	PHARMACY	0	1,171,869	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-102,963	2,601,941	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-2,391,564	8,067,137	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,419,669	31.00
43.00	04300	NURSERY	0	463,421	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	1,438,902	50.00
51.00	05100	RECOVERY ROOM	0	858,922	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	836,277	52.00
53.00	05300	ANESTHESIOLOGY	-2,096,919	38,582	53.00
53.01	05301	PAIN MANAGEMENT	0	118,564	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,058,649	1,703,521	54.00
54.01	05401	ULTRASOUND	-372,096	503,703	54.01
56.00	05600	RADIOISOTOPE	-45,917	334,603	56.00
57.00	05700	CT SCAN	-1,275,335	875,231	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-474,101	497,695	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,007,621	59.00
60.00	06000	LABORATORY	-502,251	4,627,525	60.00
65.00	06500	RESPIRATORY THERAPY	-3,003	916,280	65.00
66.00	06600	PHYSICAL THERAPY	0	286,283	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	66,701	67.00
68.00	06800	SPEECH PATHOLOGY	0	87,842	68.00
69.00	06900	ELECTROCARDIOLOGY	-26,372	858,212	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	202,657	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,890,203	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,902,113	73.00
74.00	07400	RENAL DIALYSIS	0	79,549	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
75.01	07501	GI LAB	0	992,562	75.01
76.00	03020	DIABETIC EDUCATION	0	38,170	76.00
76.01	03021	WOUND CARE	-428,281	515,925	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	-20,729,974	5,619,111	90.00
91.00	09100	EMERGENCY	-4,215,673	2,783,234	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	-21,025	1,603,442	95.00
98.00	09500	HOME INFUSION	-1,214	181,445	98.00
101.00	10100	HOME HEALTH AGENCY	-813	1,074,650	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-40,504,771	132,126,674	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	45,025	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	534,722	192.00
194.00	07950	COMMUNITY SERVICE	0	345,321	194.00
200.00		TOTAL (SUM OF LINES 118-199)	-40,504,771	133,051,742	200.00

RECLASSIFICATIONS

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		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
<b>A - TO RECLASS INTEREST EXPENSE</b>						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	797,302	1.00	
	TOTALS		0	797,302		
<b>B - TO RECLASS L&amp;D AND NURSERY COST</b>						
1.00	NURSERY	43.00	436,382	18,337	1.00	
2.00	DELIVERY ROOM & LABOR ROOM	52.00	787,486	33,090	2.00	
	TOTALS		1,223,868	51,427		
<b>C - TO RECLASS OFFSITE BLDG</b>						
1.00	OTHER CAP REL COSTS	3.00	0	38,119	1.00	
2.00	OPERATION OF PLANT	7.00	0	624,728	2.00	
3.00	HOUSEKEEPING	9.00	0	12,944	3.00	
4.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,088,485	4.00	
5.00	CAP REL COSTS-BLDG & FIXT	1.00	0	173,319	5.00	
6.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	112,664	6.00	
	TOTALS		0	2,050,259		
<b>D - TO RECLASS EMPLOYEE BENEFITS</b>						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	219,984	1.00	
	TOTALS		0	219,984		
<b>E - TO RECLASS COLL AND BILLING EXP</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	73,349	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
	TOTALS		0	73,349		
<b>F - TO RECLASS BOND AMORTIZATION</b>						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	318	1.00	
	TOTALS		0	318		
<b>G - TO RECLASS CAFETERIA EXPENSE</b>						
1.00	CAFETERIA	11.00	631,470	667,214	1.00	
	TOTALS		631,470	667,214		
<b>H - TO RECLASS DRUG EXPENSE</b>						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	11,902,113	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	
18.00		0.00	0	0	18.00	
	TOTALS		0	11,902,113		
<b>I - TO RECLASS MARKETING AND ADV</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	45,710	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	
	TOTALS		0	45,710		
<b>J - TO RECLASS TELEPHONE EXPENSE</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	113,687	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	

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		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
13.00		0.00	0	0	13.00
	TOTALS		0	113,687	
K - TO RECLASS PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	171,123	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	306,149	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
	TOTALS		0	477,272	
L - TO RECLASS MALPRACTICE INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	15,767	1.00
	TOTALS		0	15,767	
M - TO RECLASS MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	12,890,203	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
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
	TOTALS		0	12,890,203	
N - TO RECLASS POPULATION HLTH MGMT					
1.00	ADMINISTRATIVE & GENERAL	5.00	647,130	286,110	1.00
2.00	DIABETIC EDUCATION	76.00	26,202	11,584	2.00
3.00	COMMUNITY SERVICE	194.00	335,167	14,965	3.00
	TOTALS		1,008,499	312,659	
O - TO RECLASS POST ICU					
1.00	ADULTS & PEDIATRICS	30.00	681,504	23,604	1.00
	TOTALS		681,504	23,604	
P - TO RECLASS MME DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,227,160	1.00
	TOTALS		0	6,227,160	
Q - TO RECLASS UTILITIES EXPENSE					
1.00	OPERATION OF PLANT	7.00	0	6,189	1.00
	TOTALS		0	6,189	
R - TO RECLASS NURSING FLOATS					
1.00	ADULTS & PEDIATRICS	30.00	225,561	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	26,164	0	2.00
3.00	NURSERY	43.00	8,702	0	3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	15,701	0	4.00
	TOTALS		276,128	0	
T - TO RECLASS RADIOLOGY MANAGEMENT					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	230,501	14,799	1.00
2.00	ULTRASOUND	54.01	54,193	3,479	2.00
3.00	RADIOISOTOPE	56.00	32,863	2,110	3.00
4.00	CT SCAN	57.00	80,740	5,184	4.00

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Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
5.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	37,532	2,410	5.00
	TOTALS		435,829	27,982	
500.00	Grand Total: Increases		4,257,298	35,902,199	500.00

RECLASSIFICATIONS

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Decreases						Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
<b>A - TO RECLASS INTEREST EXPENSE</b>							
1.00	INTEREST EXPENSE	113.00	0	797,302	11		1.00
	TOTALS		0	797,302			
<b>B - TO RECLASS L&amp;D AND NURSERY COST</b>							
1.00	ADULTS & PEDIATRICS	30.00	1,223,868	51,427	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		1,223,868	51,427			
<b>C - TO RECLASS OFFSITE BLDG</b>							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,937,595	5		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	112,664	9		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	10		4.00
5.00		0.00	0	0	13		5.00
6.00		0.00	0	0	0		6.00
	TOTALS		0	2,050,259			
<b>D - TO RECLASS EMPLOYEE BENEFITS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	219,984	0		1.00
	TOTALS		0	219,984			
<b>E - TO RECLASS COLL AND BILLING EXP</b>							
1.00	LABORATORY	60.00	0	192	0		1.00
2.00	CLINIC	90.00	0	820	0		2.00
3.00	AMBULANCE SERVICES	95.00	0	45,864	0		3.00
4.00	HOME INFUSION	98.00	0	8,581	0		4.00
5.00	HOME HEALTH AGENCY	101.00	0	17,892	0		5.00
	TOTALS		0	73,349			
<b>F - TO RECLASS BOND AMORTIZATION</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	318	14		1.00
	TOTALS		0	318			
<b>G - TO RECLASS CAFETERIA EXPENSE</b>							
1.00	DIETARY	10.00	631,470	667,214	0		1.00
	TOTALS		631,470	667,214			
<b>H - TO RECLASS DRUG EXPENSE</b>							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	173	0		1.00
2.00	PHARMACY	15.00	0	3,493,327	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	1,895	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	601	0		4.00
5.00	RECOVERY ROOM	51.00	0	59	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	200,664	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	14,460	0		7.00
8.00	RADIOISOTOPE	56.00	0	274,477	0		8.00
9.00	CARDIAC CATHETERIZATION	59.00	0	885	0		9.00
10.00	LABORATORY	60.00	0	148	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	1,281	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	1,725	0		12.00
13.00	GI LAB	75.01	0	224	0		13.00
14.00	WOUND CARE	76.01	0	10,422	0		14.00
15.00	CLINIC	90.00	0	7,891,746	0		15.00
16.00	EMERGENCY	91.00	0	3,528	0		16.00
17.00	AMBULANCE SERVICES	95.00	0	3,050	0		17.00
18.00	HOME HEALTH AGENCY	101.00	0	3,448	0		18.00
	TOTALS		0	11,902,113			
<b>I - TO RECLASS MARKETING AND ADV</b>							
1.00	HOUSEKEEPING	9.00	0	20	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	2,241	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	1,230	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	913	0		4.00
5.00	CT SCAN	57.00	0	2,142	0		5.00
6.00	ELECTROCARDIOLOGY	69.00	0	81	0		6.00
7.00	WOUND CARE	76.01	0	983	0		7.00
8.00	HOME HEALTH AGENCY	101.00	0	38,100	0		8.00
	TOTALS		0	45,710			
<b>J - TO RECLASS TELEPHONE EXPENSE</b>							
1.00	OPERATION OF PLANT	7.00	0	432	0		1.00
2.00	PHARMACY	15.00	0	531	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	8,862	0		3.00
4.00	OPERATING ROOM	50.00	0	2,758	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	2,319	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,282	0		6.00
7.00	LABORATORY	60.00	0	3,237	0		7.00
8.00	ELECTROCARDIOLOGY	69.00	0	306	0		8.00
9.00	CLINIC	90.00	0	78,061	0		9.00
10.00	EMERGENCY	91.00	0	455	0		10.00
11.00	AMBULANCE SERVICES	95.00	0	9,213	0		11.00
12.00	HOME HEALTH AGENCY	101.00	0	5,707	0		12.00

RECLASSIFICATIONS

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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
13.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	524	0		13.00
	TOTALS		0	113,687			
K - TO RECLASS PROPERTY INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	7,038	0		1.00
2.00	HOUSEKEEPING	9.00	0	723	13		2.00
3.00	OPERATION OF PLANT	7.00	0	130,246	0		3.00
4.00	LABORATORY	60.00	0	289	0		4.00
5.00	AMBULANCE SERVICES	95.00	0	21,938	0		5.00
6.00	HOME HEALTH AGENCY	101.00	0	10,889	0		6.00
7.00	OPERATION OF PLANT	7.00	0	306,149	0		7.00
	TOTALS		0	477,272			
L - TO RECLASS MALPRACTICE INSURANCE							
1.00	AMBULANCE SERVICES	95.00	0	15,767	0		1.00
	TOTALS		0	15,767			
M - TO RECLASS MEDICAL SUPPLIES							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	620	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	211,300	0		2.00
3.00	PHARMACY	15.00	0	78,867	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	446,562	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	106,589	0		5.00
6.00	OPERATING ROOM	50.00	0	4,478,033	0		6.00
7.00	RECOVERY ROOM	51.00	0	158,366	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	192,646	0		8.00
9.00	PAIN MANAGEMENT	53.01	0	39,842	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	46,854	0		10.00
11.00	ULTRASOUND	54.01	0	7,366	0		11.00
12.00	RADIOISOTOPE	56.00	0	636,276	0		12.00
13.00	CT SCAN	57.00	0	126,633	0		13.00
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	46,867	0		14.00
15.00	CARDIAC CATHETERIZATION	59.00	0	2,440,849	0		15.00
16.00	LABORATORY	60.00	0	1,575,949	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	148,929	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	6,563	0		18.00
19.00	OCCUPATIONAL THERAPY	67.00	0	3,238	0		19.00
20.00	ELECTROCARDIOLOGY	69.00	0	31,965	0		20.00
21.00	ELECTROENCEPHALOGRAPHY	70.00	0	14,461	0		21.00
22.00	RENAL DIALYSIS	74.00	0	644	0		22.00
23.00	GI LAB	75.01	0	505,266	0		23.00
24.00	WOUND CARE	76.01	0	108,547	0		24.00
25.00	CLINIC	90.00	0	989,129	0		25.00
26.00	EMERGENCY	91.00	0	415,089	0		26.00
27.00	AMBULANCE SERVICES	95.00	0	19,979	0		27.00
28.00	HOME INFUSION	98.00	0	24,709	0		28.00
29.00	HOME HEALTH AGENCY	101.00	0	18,607	0		29.00
30.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	9,200	0		30.00
31.00	COMMUNITY SERVICE	194.00	0	258	0		31.00
	TOTALS		0	12,890,203			
N - TO RECLASS POPULATION HLTH MGMT							
1.00	CLINIC	90.00	1,008,499	312,659	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		1,008,499	312,659			
O - TO RECLASS POST ICU							
1.00	INTENSIVE CARE UNIT	31.00	681,504	23,604	0		1.00
	TOTALS		681,504	23,604			
P - TO RECLASS MME DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,227,160	9		1.00
	TOTALS		0	6,227,160			
Q - TO RECLASS UTILITIES EXPENSE							
1.00	AMBULANCE SERVICES	95.00	0	6,189	0		1.00
	TOTALS		0	6,189			
R - TO RECLASS NURSING FLOATS							
1.00	NURSING ADMINISTRATION	13.00	276,128	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		276,128	0			
T - TO RECLASS RADIOLOGY MANAGEMENT							
1.00	ADMINISTRATIVE & GENERAL	5.00	435,829	27,982	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00

Provider CCN: 140043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet A-6  
Date/Time Prepared:  
9/26/2014 5:19 pm

Decreases					Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other			
6.00	7.00	8.00	9.00	10.00		
TOTALS		435,829	27,982			
500.00	Grand Total: Decreases		4,257,298	35,902,199		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet A-7  
Part I  
Date/Time Prepared:  
9/26/2014 5:19 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	2,593,156	56,243	0	56,243	0 1.00
2.00	Land Improvements	2,179,633	1,580,522	0	1,580,522	0 2.00
3.00	Buildings and Fixtures	77,119,008	3,700,175	0	3,700,175	490,969 3.00
4.00	Building Improvements	14,004,780	0	0	0	268,629 4.00
5.00	Fixed Equipment	449,516	57,837	0	57,837	51,770 5.00
6.00	Movable Equipment	62,540,768	4,976,974	0	4,976,974	4,492,401 6.00
7.00	HIT designated Assets	0	0	0	0	0 7.00
8.00	Subtotal (sum of lines 1-7)	158,886,861	10,371,751	0	10,371,751	5,303,769 8.00
9.00	Reconciling Items	0	0	0	0	0 9.00
10.00	Total (line 8 minus line 9)	158,886,861	10,371,751	0	10,371,751	5,303,769 10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	2,649,399	0			1.00
2.00	Land Improvements	3,760,155	0			2.00
3.00	Buildings and Fixtures	80,328,214	0			3.00
4.00	Building Improvements	13,736,151	0			4.00
5.00	Fixed Equipment	455,583	0			5.00
6.00	Movable Equipment	63,025,341	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	163,954,843	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	163,954,843	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet A-7  
Part II  
Date/Time Prepared:  
9/26/2014 5:19 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	9,544,834	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	9,544,834	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	9,544,834				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	9,544,834				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet A-7  
Part III  
Date/Time Prepared:  
9/26/2014 5:19 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	100,473,918	0	100,473,918	0.612815	128,227	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	63,480,925	0	63,480,925	0.387185	81,015	2.00
3.00	Total (sum of lines 1-2)	163,954,843	0	163,954,843	1.000000	209,242	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	128,227	3,205,010	1,088,485	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	81,015	6,221,522	0	2.00
3.00	Total (sum of lines 1-2)	0	0	209,242	9,426,532	1,088,485	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	128,227	479,468	318	4,901,508	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	81,015	0	0	6,302,537	2.00
3.00	Total (sum of lines 1-2)	0	209,242	479,468	318	11,204,045	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet A-8

Date/Time Prepared:  
9/26/2014 5:19 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-797,302	CAP REL COSTS-BLDG & FIXT	1.00	11	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)	B	-19,309	ADMINISTRATIVE & GENERAL	5.00	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)	B	-123	ADMINISTRATIVE & GENERAL	5.00	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	-31,551,984			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-740,762	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	-102,223	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	B	-2,559	CAFETERIA	11.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	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	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00 DAYCARE RENT	B	-18,000	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01 DIETARY CATERING REVENUE	B	-6,872	DIETARY	10.00	0	33.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 140043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet A-8

Date/Time Prepared:  
9/26/2014 5:19 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
33.02 RENTAL INCOME	B	-640	ADMINISTRATIVE & GENERAL		5.00	0 33.02
33.03 MISCELLANEOUS INCOME	B	-277	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.03
33.04 MISCELLANEOUS INCOME	B	-66,311	ADMINISTRATIVE & GENERAL		5.00	0 33.04
33.05 MISCELLANEOUS INCOME	B	-3,003	RESPIRATORY THERAPY		65.00	0 33.05
33.06 LIFESTYLE MEDICINE INCOME	B	-6,570	ELECTROCARDIOLOGY		69.00	0 33.06
33.07 CARDIAC REHAB PHASE III REVENUE	B	-19,802	ELECTROCARDIOLOGY		69.00	0 33.07
33.08 MISCELLANEOUS INCOME	B	-6,120	CT SCAN		57.00	0 33.08
33.09 BLOOD DRAW INCOME	B	-1,214	HOME INFUSION		98.00	0 33.09
33.10 OUTSIDE TRANSCRIPTION REVENUE	B	-40	MEDICAL RECORDS & LIBRARY		16.00	0 33.10
33.11		0			0.00	0 33.11
33.12 HOUSEKEEPING REVENUE	B	-387	HOUSEKEEPING		9.00	0 33.12
33.13 PATIENT ACCOUNTING REVENUE	B	-72,098	ADMINISTRATIVE & GENERAL		5.00	0 33.13
33.14 DAYCARE REVENUE	B	-579,763	ADMINISTRATIVE & GENERAL		5.00	0 33.14
33.15 DAYCARE DISCOUNT EXPENSE	A	-32,824	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.15
33.16 ELIMINATION DONATION EXPENSE	A	-402,699	ADMINISTRATIVE & GENERAL		5.00	0 33.16
33.17		0			0.00	0 33.17
33.18 LOBBYING EXPENSE	A	-51,607	ADMINISTRATIVE & GENERAL		5.00	0 33.18
33.19 PHYSICIAN RECRUITMENT SALARIES	A	-70,091	ADMINISTRATIVE & GENERAL		5.00	0 33.19
33.20 PHYSICIAN RECRUITMENT OTHER	A	-447,417	ADMINISTRATIVE & GENERAL		5.00	0 33.20
33.21 PHYSICIAN RECRUITMENT BENEFITS	A	-31,214	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.21
33.22 MARKETING SALARIES	A	-217,348	ADMINISTRATIVE & GENERAL		5.00	0 33.22
33.23 MARKETING OTHER EXPENSES	A	-527,484	ADMINISTRATIVE & GENERAL		5.00	0 33.23
33.24 MARKETING DEPRECIATION	A	-5,638	CAP REL COSTS-MVBLE EQUIP		2.00	9 33.24
33.25 MARKETING BENEFITS	A	-100,350	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.25
33.26 CABLE TELEVISION	A	-3,861	CENTRAL SERVICES & SUPPLY		14.00	0 33.26
33.27 CABLE TELEVISION	A	-43,403	ADMINISTRATIVE & GENERAL		5.00	0 33.27
33.28 CABLE TELEVISION	A	-2,081	OPERATION OF PLANT		7.00	0 33.28
33.29 CABLE TELEVISION	A	-633	CLINIC		90.00	0 33.29
33.30 PHYSICIAN BENEFITS	A	-2,179,799	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.30
33.31 CRNA LOCUM TENENS	A	-18,357	ANESTHESIOLOGY		53.00	0 33.31
33.32 CRNA PHYSICIAN CME EXPENSE	A	-9,041	ANESTHESIOLOGY		53.00	0 33.32
33.33 CRNA FICA TAXES	A	-53,328	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.33
33.34 CRNA MEDICARE TAXES	A	-28,876	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.34
33.35 CRNA BENEFIT OFFSET	A	-176,645	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.35
33.36 CRNA SALARIES	A	-2,037,354	ANESTHESIOLOGY		53.00	0 33.36
33.37 CRNA MALPRACTICE INSURANCE	A	-32,167	ANESTHESIOLOGY		53.00	0 33.37
33.38 ALCOHOLIC BEVERAGES	A	-2,562	ADMINISTRATIVE & GENERAL		5.00	0 33.38
33.39 CONTRACT INCOME	B	-182	ADMINISTRATIVE & GENERAL		5.00	0 33.39
33.40 MISCELLANEOUS INCOME	B	-1,000	RADIOLOGY-DIAGNOSTIC		54.00	0 33.40
33.41 MISCELLANEOUS INCOME	B	-21,025	AMBULANCE SERVICES		95.00	0 33.41
33.42 MISCELLANEOUS INCOME	B	-8,468	OPERATION OF PLANT		7.00	0 33.42
33.43 MISCELLANEOUS INCOME	B	-400	OPERATION OF PLANT		7.00	0 33.43
33.44 MISCELLANEOUS INCOME	B	-45	ADULTS & PEDIATRICS		30.00	0 33.44
33.45 MISCELLANEOUS INCOME	B	-2,000	NURSING ADMINISTRATION		13.00	0 33.45
33.46 SRFC TRANSCRIPTION	B	-700	MEDICAL RECORDS & LIBRARY		16.00	0 33.46
33.47 HOME NURSING INCOME	B	-813	HOME HEALTH AGENCY		101.00	0 33.47
33.48		0			0.00	0 33.48
33.49		0			0.00	0 33.49
33.50		0			0.00	0 33.50
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-40,504,771				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet A-8-2

Date/Time Prepared:  
9/26/2014 5:19 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	5.00	ADMINISTRATIVE & GENERAL	135,162	0	135,162	159,800	901	1.00
2.00	30.00	ADULTS & PEDIATRICS	2,391,519	2,391,519	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	1,057,649	1,057,649	0	0	0	3.00
4.00	54.01	ULTRASOUND	372,096	372,096	0	0	0	4.00
5.00	56.00	RADIOISOTOPE	45,917	45,917	0	0	0	5.00
6.00	57.00	CT SCAN	1,269,215	1,269,215	0	0	0	6.00
7.00	58.00	MAGNETIC RESONANCE IMAGING (MRI)	474,101	474,101	0	0	0	7.00
8.00	60.00	LABORATORY	502,251	502,251	0	0	0	8.00
9.00	76.01	WOUND CARE	428,281	428,281	0	0	0	9.00
10.00	90.00	CLINIC	20,729,341	20,729,341	0	0	0	10.00
11.00	91.00	EMERGENCY	4,215,673	4,215,673	0	0	0	11.00
200.00			31,621,205	31,486,043	135,162		901	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	5.00	ADMINISTRATIVE & GENERAL	69,221	3,461	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	9,264	0	88,629	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	54.01	ULTRASOUND	0	0	0	0	0	4.00
5.00	56.00	RADIOISOTOPE	0	0	0	0	0	5.00
6.00	57.00	CT SCAN	0	0	0	0	0	6.00
7.00	58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	7.00
8.00	60.00	LABORATORY	0	0	4,512	0	12,229	8.00
9.00	76.01	WOUND CARE	0	0	1,932	0	0	9.00
10.00	90.00	CLINIC	0	0	134,172	0	777,185	10.00
11.00	91.00	EMERGENCY	0	0	0	0	0	11.00
200.00			69,221	3,461	149,880	0	878,043	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	5.00	ADMINISTRATIVE & GENERAL	0	69,221	65,941	65,941	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,391,519	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,057,649	3.00
4.00	54.01	ULTRASOUND	0	0	0	372,096	4.00
5.00	56.00	RADIOISOTOPE	0	0	0	45,917	5.00
6.00	57.00	CT SCAN	0	0	0	1,269,215	6.00
7.00	58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	474,101	7.00
8.00	60.00	LABORATORY	0	0	0	502,251	8.00
9.00	76.01	WOUND CARE	0	0	0	428,281	9.00
10.00	90.00	CLINIC	0	0	0	20,729,341	10.00
11.00	91.00	EMERGENCY	0	0	0	4,215,673	11.00
200.00			0	69,221	65,941	31,551,984	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet B  
Part I  
Date/Time Prepared:  
9/26/2014 5:19 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	4,901,508	4,901,508			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	6,302,537		6,302,537		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	28,036,689	9,132	5,441	28,051,262	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	18,438,457	1,013,936	2,388,544	6,058,696	5.00
7.00 00700	OPERATION OF PLANT	3,444,872	181,954	338,243	555,671	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	396,098	72,131	28,955	152,648	8.00
9.00 00900	HOUSEKEEPING	1,544,682	7,500	2,233	493,270	9.00
10.00 01000	DIETARY	474,681	25,348	65,433	128,906	10.00
11.00 01100	CAFETERIA	555,363	68,401	0	347,828	11.00
13.00 01300	NURSING ADMINISTRATION	948,831	2,027	32,890	444,662	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	419,394	10,591	34,541	184,715	14.00
15.00 01500	PHARMACY	1,171,869	18,284	33,137	486,658	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,601,941	54,851	65,650	923,763	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	8,067,137	482,497	331,100	4,348,790	30.00
31.00 03100	INTENSIVE CARE UNIT	1,419,669	102,424	38,857	756,290	31.00
43.00 04300	NURSERY	463,421	87,364	24,996	245,162	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	1,438,902	246,767	504,536	650,012	50.00
51.00 05100	RECOVERY ROOM	858,922	136,904	38,727	465,858	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	836,277	100,144	45,098	442,413	52.00
53.00 05300	ANESTHESIOLOGY	38,582	6,486	12,589	0	53.00
53.01 05301	PAIN MANAGEMENT	118,564	15,811	9,027	63,562	53.01
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,703,521	176,491	415,889	760,491	54.00
54.01 05401	ULTRASOUND	503,703	29,614	113,429	243,119	54.01
56.00 05600	RADIOISOTOPE	334,603	69,790	180,323	153,803	56.00
57.00 05700	CT SCAN	875,231	19,175	67,652	335,512	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	497,695	40,712	50,550	178,408	58.00
59.00 05900	CARDIAC CATHETERIZATION	1,007,621	79,661	513,962	425,047	59.00
60.00 06000	LABORATORY	4,627,525	123,353	324,710	1,247,934	60.00
65.00 06500	RESPIRATORY THERAPY	916,280	52,844	54,622	442,236	65.00
66.00 06600	PHYSICAL THERAPY	286,283	9,973	3,789	152,475	66.00
67.00 06700	OCCUPATIONAL THERAPY	66,701	4,064	0	36,633	67.00
68.00 06800	SPEECH PATHOLOGY	87,842	1,216	0	46,331	68.00
69.00 06900	ELECTROCARDIOLOGY	858,212	40,763	221,150	439,488	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	202,657	13,287	18,213	94,422	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,890,203	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	11,902,113	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	79,549	2,554	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01 07501	GI LAB	992,562	39,151	82,057	494,633	75.01
76.00 03020	DIABETIC EDUCATION	38,170	15,760	321	14,644	76.00
76.01 03021	WOUND CARE	515,925	23,807	2,387	125,014	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	5,619,111	1,325,636	100,559	2,895,328	90.00
91.00 09100	EMERGENCY	2,783,234	80,441	40,145	1,474,792	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	1,603,442	24,000	71,004	815,928	95.00
98.00 05950	HOME INFUSION	181,445	2,128	0	29,139	98.00
101.00 10100	HOME HEALTH AGENCY	1,074,650	21,527	34,702	544,951	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	132,126,674	4,838,499	6,295,461	27,699,232	131,704,559
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	45,025	12,841	1,406	7,007	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	534,722	25,358	0	164,442	192.00
194.00 07950	COMMUNITY SERVICE	345,321	24,810	5,670	180,581	194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	133,051,742	4,901,508	6,302,537	28,051,262	133,051,742

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet B  
Part I  
Date/Time Prepared:  
9/26/2014 5:19 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	27,899,633				5.00	
7.00	00700	OPERATION OF PLANT	1,199,470	5,720,210			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	172,417	111,620	933,869		8.00	
9.00	00900	HOUSEKEEPING	543,304	11,606	50,353	2,652,948	9.00	
10.00	01000	DIETARY	184,234	39,225	25,256	18,592	961,675	10.00
11.00	01100	CAFETERIA	257,789	105,849	0	50,172	0	11.00
13.00	01300	NURSING ADMINISTRATION	378,994	3,137	0	1,487	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	172,261	16,389	0	7,769	0	14.00
15.00	01500	PHARMACY	453,694	28,293	0	13,411	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	967,433	84,880	0	40,233	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	3,510,179	746,650	445,283	353,909	895,140	30.00
31.00	03100	INTENSIVE CARE UNIT	614,824	158,499	36,652	75,128	56,912	31.00
43.00	04300	NURSERY	217,818	135,193	6,328	64,081	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	753,583	381,865	38,231	181,002	0	50.00
51.00	05100	RECOVERY ROOM	398,098	211,854	17,669	100,418	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	377,806	154,970	11,417	73,455	0	52.00
53.00	05300	ANESTHESIOLOGY	15,298	10,038	0	4,758	0	53.00
53.01	05301	PAIN MANAGEMENT	54,913	24,466	0	11,597	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	810,940	273,115	42,369	129,455	0	54.00
54.01	05401	ULTRASOUND	236,104	45,828	0	21,722	0	54.01
56.00	05600	RADIO SOTOPE	195,948	107,997	0	51,190	0	56.00
57.00	05700	CT SCAN	344,279	29,673	0	14,065	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	203,602	63,001	0	29,862	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	537,628	123,273	19,579	58,431	2,989	59.00
60.00	06000	LABORATORY	1,677,795	190,885	219	90,479	0	60.00
65.00	06500	RESPIRATORY THERAPY	388,963	81,774	9	38,761	0	65.00
66.00	06600	PHYSICAL THERAPY	120,065	15,433	9,346	7,315	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	28,495	6,289	0	2,981	0	67.00
68.00	06800	SPEECH PATHOLOGY	35,922	1,882	0	892	0	68.00
69.00	06900	ELECTROCARDIOLOGY	413,806	63,080	10,302	29,899	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	87,181	20,561	7,809	9,746	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,420,106	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	3,157,940	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	21,784	3,952	0	1,873	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	GI LAB	426,751	60,586	48,552	28,717	0	75.01
76.00	03020	DIABETIC EDUCATION	18,280	24,388	0	11,560	0	76.00
76.01	03021	WOUND CARE	177,008	36,841	6,783	17,462	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	2,637,509	2,051,387	31,040	972,351	0	90.00
91.00	09100	EMERGENCY	1,161,760	124,481	76,628	59,003	6,634	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	667,129	37,139	32,080	17,604	0	95.00
98.00	09500	HOME INFUSION	56,438	3,294	0	1,561	0	98.00
101.00	10100	HOME HEALTH AGENCY	444,641	33,312	0	15,790	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,542,189	5,622,705	915,905	2,606,731	961,675	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,586	19,871	0	9,419	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192,235	39,240	16,559	18,600	0	192.00
194.00	07950	COMMUNITY SERVICE	147,623	38,394	1,405	18,198	0	194.00
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)	27,899,633	5,720,210	933,869	2,652,948	961,675	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140043	Period: From 05/01/2013 To 04/30/2014	Worksheet B Part I Date/Time Prepared: 9/26/2014 5:19 pm
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	1,385,402					11.00
13.00	01300	15,241	1,827,269				13.00
14.00	01400	14,029	0	859,689			14.00
15.00	01500	22,614	0	0	2,227,960		15.00
16.00	01600	70,026	0	0	0	4,808,777	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	283,655	558,726	171	0	307,873	30.00
31.00	03100	43,675	86,032	136	0	63,954	31.00
43.00	04300	10,957	21,588	0	0	23,472	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	32,018	63,053	192	0	288,737	50.00
51.00	05100	23,177	45,662	266	0	47,028	51.00
52.00	05200	19,781	38,958	0	0	42,358	52.00
53.00	05300	0	0	0	0	94,658	53.00
53.01	05301	3,584	7,052	157	0	34,434	53.01
54.00	05400	48,470	0	0	0	184,560	54.00
54.01	05401	11,469	0	0	0	92,432	54.01
56.00	05600	6,963	0	0	0	106,656	56.00
57.00	05700	17,101	0	0	0	415,362	57.00
58.00	05800	7,953	0	0	0	134,047	58.00
59.00	05900	20,480	40,348	0	0	302,150	59.00
60.00	06000	91,616	0	0	0	859,951	60.00
65.00	06500	24,013	0	301	0	42,653	65.00
66.00	06600	9,967	0	313	0	8,864	66.00
67.00	06700	1,263	0	0	0	1,706	67.00
68.00	06800	1,638	0	0	0	2,128	68.00
69.00	06900	28,656	56,435	157	0	148,477	69.00
70.00	07000	7,185	0	0	0	26,490	70.00
71.00	07100	0	0	856,937	0	197,082	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	2,227,960	398,677	73.00
74.00	07400	0	0	0	0	2,314	74.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	22,648	0	179	0	135,065	75.01
76.00	03020	956	0	0	0	3,168	76.00
76.01	03021	9,421	0	0	0	33,718	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	345,302	680,159	397	0	341,140	90.00
91.00	09100	85,250	167,929	157	0	403,184	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	58,660	0	38	0	44,958	95.00
98.00	05950	2,253	4,430	0	0	7,160	98.00
101.00	10100	26,266	51,754	174	0	14,321	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		1,366,287	1,822,126	859,575	2,227,960	4,808,777	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	1,502	0	114	0	0	190.00
192.00	19200	6,997	0	0	0	0	192.00
194.00	07950	10,616	5,143	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,385,402	1,827,269	859,689	2,227,960	4,808,777	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet B  
Part I  
Date/Time Prepared:  
9/26/2014 5:19 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	20,331,110	0	20,331,110	30.00
31.00	03100	3,453,052	0	3,453,052	31.00
43.00	04300	1,300,380	0	1,300,380	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	4,578,898	0	4,578,898	50.00
51.00	05100	2,344,583	0	2,344,583	51.00
52.00	05200	2,142,677	0	2,142,677	52.00
53.00	05300	182,409	0	182,409	53.00
53.01	05301	343,167	0	343,167	53.01
54.00	05400	4,545,301	0	4,545,301	54.00
54.01	05401	1,297,420	0	1,297,420	54.01
56.00	05600	1,207,273	0	1,207,273	56.00
57.00	05700	2,118,050	0	2,118,050	57.00
58.00	05800	1,205,830	0	1,205,830	58.00
59.00	05900	3,131,169	0	3,131,169	59.00
60.00	06000	9,234,467	0	9,234,467	60.00
65.00	06500	2,042,456	0	2,042,456	65.00
66.00	06600	623,823	0	623,823	66.00
67.00	06700	148,132	0	148,132	67.00
68.00	06800	177,851	0	177,851	68.00
69.00	06900	2,310,425	0	2,310,425	69.00
70.00	07000	487,551	0	487,551	70.00
71.00	07100	17,364,328	0	17,364,328	71.00
72.00	07200	0	0	0	72.00
73.00	07300	17,686,690	0	17,686,690	73.00
74.00	07400	112,026	0	112,026	74.00
75.00	07500	0	0	0	75.00
75.01	07501	2,330,901	0	2,330,901	75.01
76.00	03020	127,247	0	127,247	76.00
76.01	03021	948,366	0	948,366	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	16,999,919	0	16,999,919	90.00
91.00	09100	6,463,638	0	6,463,638	91.00
92.00	09200		0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	3,371,982	0	3,371,982	95.00
98.00	05950	287,848	0	287,848	98.00
101.00	10100	2,262,088	0	2,262,088	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300				113.00
118.00		131,161,057	0	131,161,057	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	114,771	0	114,771	190.00
192.00	19200	998,153	0	998,153	192.00
194.00	07950	777,761	0	777,761	194.00
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		133,051,742	0	133,051,742	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140043	Period: From 05/01/2013 To 04/30/2014	Worksheet B Part II Date/Time Prepared: 9/26/2014 5:19 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,132	5,441	14,573	14,573 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	56,138	1,013,936	2,388,544	3,458,618	3,150 5.00
7.00 00700	OPERATION OF PLANT	2,595	181,954	338,243	522,792	289 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	72,131	28,955	101,086	79 8.00
9.00 00900	HOUSEKEEPING	0	7,500	2,233	9,733	256 9.00
10.00 01000	DIETARY	0	25,348	65,433	90,781	67 10.00
11.00 01100	CAFETERIA	0	68,401	0	68,401	181 11.00
13.00 01300	NURSING ADMINISTRATION	0	2,027	32,890	34,917	231 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	10,591	34,541	45,132	96 14.00
15.00 01500	PHARMACY	0	18,284	33,137	51,421	253 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	54,851	65,650	120,501	480 16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	482,497	331,100	813,597	2,258 30.00
31.00 03100	INTENSIVE CARE UNIT	0	102,424	38,857	141,281	393 31.00
43.00 04300	NURSERY	0	87,364	24,996	112,360	127 43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	54,314	246,767	504,536	805,617	338 50.00
51.00 05100	RECOVERY ROOM	0	136,904	38,727	175,631	242 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	100,144	45,098	145,242	230 52.00
53.00 05300	ANESTHESIOLOGY	0	6,486	12,589	19,075	0 53.00
53.01 05301	PAIN MANAGEMENT	0	15,811	9,027	24,838	33 53.01
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	176,491	415,889	592,380	395 54.00
54.01 05401	ULTRASOUND	0	29,614	113,429	143,043	126 54.01
56.00 05600	RADIO SOTOPE	0	69,790	180,323	250,113	80 56.00
57.00 05700	CT SCAN	0	19,175	67,652	86,827	174 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	40,712	50,550	91,262	93 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	79,661	513,962	593,623	221 59.00
60.00 06000	LABORATORY	0	123,353	324,710	448,063	648 60.00
65.00 06500	RESPIRATORY THERAPY	0	52,844	54,622	107,466	230 65.00
66.00 06600	PHYSICAL THERAPY	0	9,973	3,789	13,762	79 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	4,064	0	4,064	19 67.00
68.00 06800	SPEECH PATHOLOGY	0	1,216	0	1,216	24 68.00
69.00 06900	ELECTROCARDIOLOGY	0	40,763	221,150	261,913	228 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	1,002	13,287	18,213	32,502	49 70.00
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
74.00 07400	RENAL DIALYSIS	0	2,554	0	2,554	0 74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
75.01 07501	GI LAB	0	39,151	82,057	121,208	257 75.01
76.00 03020	DIABETIC EDUCATION	0	15,760	321	16,081	8 76.00
76.01 03021	WOUND CARE	0	23,807	2,387	26,194	65 76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	1,665	1,325,636	100,559	1,427,860	1,503 90.00
91.00 09100	EMERGENCY	0	80,441	40,145	120,586	766 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	24,000	71,004	95,004	424 95.00
98.00 05950	HOME INFUSION	0	2,128	0	2,128	15 98.00
101.00 10100	HOME HEALTH AGENCY	0	21,527	34,702	56,229	283 101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	115,714	4,838,499	6,295,461	11,249,674	14,390 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,841	1,406	14,247	4 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	171,724	25,358	0	197,082	85 192.00
194.00 07950	COMMUNITY SERVICE	0	24,810	5,670	30,480	94 194.00
200.00	Cross Foot Adjustments				0	0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	287,438	4,901,508	6,302,537	11,491,483	14,573 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140043	Period: From 05/01/2013 To 04/30/2014	Worksheet B Part II Date/Time Prepared: 9/26/2014 5:19 pm				
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	3,461,768				5.00	
7.00	00700	OPERATION OF PLANT	148,832	671,913			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	21,394	13,111	135,670		8.00	
9.00	00900	HOUSEKEEPING	67,414	1,363	7,315	86,081	9.00	
10.00	01000	DIETARY	22,860	4,607	3,669	603	122,587	10.00
11.00	01100	CAFETERIA	31,987	12,433	0	1,628	0	11.00
13.00	01300	NURSING ADMINISTRATION	47,026	368	0	48	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	21,374	1,925	0	252	0	14.00
15.00	01500	PHARMACY	56,295	3,323	0	435	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	120,040	9,970	0	1,305	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	435,490	87,704	64,691	11,483	114,105	30.00
31.00	03100	INTENSIVE CARE UNIT	76,288	18,618	5,325	2,438	7,255	31.00
43.00	04300	NURSERY	27,027	15,880	919	2,079	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	93,506	44,855	5,554	5,873	0	50.00
51.00	05100	RECOVERY ROOM	49,397	24,885	2,567	3,258	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	46,879	18,203	1,659	2,383	0	52.00
53.00	05300	ANESTHESIOLOGY	1,898	1,179	0	154	0	53.00
53.01	05301	PAIN MANAGEMENT	6,814	2,874	0	376	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	100,623	32,081	6,155	4,200	0	54.00
54.01	05401	ULTRASOUND	29,296	5,383	0	705	0	54.01
56.00	05600	RADIO SOTOP	24,314	12,686	0	1,661	0	56.00
57.00	05700	CT SCAN	42,719	3,486	0	456	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	25,263	7,400	0	969	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	66,710	14,480	2,844	1,896	381	59.00
60.00	06000	LABORATORY	208,183	22,422	32	2,936	0	60.00
65.00	06500	RESPIRATORY THERAPY	48,263	9,605	1	1,258	0	65.00
66.00	06600	PHYSICAL THERAPY	14,898	1,813	1,358	237	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,536	739	0	97	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,457	221	0	29	0	68.00
69.00	06900	ELECTROCARDIOLOGY	51,346	7,410	1,497	970	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,817	2,415	1,135	316	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	424,371	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	391,841	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,703	464	0	61	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	GI LAB	52,952	7,117	7,053	932	0	75.01
76.00	03020	DIABETIC EDUCATION	2,268	2,865	0	375	0	76.00
76.01	03021	WOUND CARE	21,963	4,327	985	567	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	327,266	240,964	4,509	31,553	0	90.00
91.00	09100	EMERGENCY	144,153	14,622	11,132	1,914	846	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	82,778	4,362	4,660	571	0	95.00
98.00	09500	HOME INFUSION	7,003	387	0	51	0	98.00
101.00	10100	HOME HEALTH AGENCY	55,172	3,913	0	512	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,417,416	660,460	133,060	84,581	122,587	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,182	2,334	0	306	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	23,853	4,609	2,406	604	0	192.00
194.00	07950	COMMUNITY SERVICE	18,317	4,510	204	590	0	194.00
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)	3,461,768	671,913	135,670	86,081	122,587	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140043	Period: From 05/01/2013 To 04/30/2014	Worksheet B Part II Date/Time Prepared: 9/26/2014 5:19 pm
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	114,630					11.00
13.00	01300	1,261	83,851				13.00
14.00	01400	1,161	0	69,940			14.00
15.00	01500	1,871	0	0	113,598		15.00
16.00	01600	5,794	0	0	0	258,090	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	23,470	25,639	14	0	16,533	30.00
31.00	03100	3,614	3,948	11	0	3,434	31.00
43.00	04300	907	991	0	0	1,260	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	2,649	2,893	16	0	15,505	50.00
51.00	05100	1,918	2,095	22	0	2,525	51.00
52.00	05200	1,637	1,788	0	0	2,275	52.00
53.00	05300	0	0	0	0	5,083	53.00
53.01	05301	297	324	13	0	1,849	53.01
54.00	05400	4,011	0	0	0	9,911	54.00
54.01	05401	949	0	0	0	4,964	54.01
56.00	05600	576	0	0	0	5,727	56.00
57.00	05700	1,415	0	0	0	22,305	57.00
58.00	05800	658	0	0	0	7,198	58.00
59.00	05900	1,695	1,852	0	0	16,225	59.00
60.00	06000	7,580	0	0	0	46,042	60.00
65.00	06500	1,987	0	24	0	2,290	65.00
66.00	06600	825	0	25	0	476	66.00
67.00	06700	104	0	0	0	92	67.00
68.00	06800	136	0	0	0	114	68.00
69.00	06900	2,371	2,590	13	0	7,973	69.00
70.00	07000	595	0	0	0	1,422	70.00
71.00	07100	0	0	69,716	0	10,583	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	113,598	21,409	73.00
74.00	07400	0	0	0	0	124	74.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	1,874	0	15	0	7,253	75.01
76.00	03020	79	0	0	0	170	76.00
76.01	03021	780	0	0	0	1,811	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	28,568	31,211	32	0	18,319	90.00
91.00	09100	7,054	7,706	13	0	21,651	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	4,854	0	3	0	2,414	95.00
98.00	05950	186	203	0	0	384	98.00
101.00	10100	2,173	2,375	14	0	769	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		113,049	83,615	69,931	113,598	258,090	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	124	0	9	0	0	190.00
192.00	19200	579	0	0	0	0	192.00
194.00	07950	878	236	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		114,630	83,851	69,940	113,598	258,090	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140043	Period: From 05/01/2013 To 04/30/2014	Worksheet B Part II Date/Time Prepared: 9/26/2014 5:19 pm
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
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
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	1,594,984	0	1,594,984
31.00	03100	INTENSIVE CARE UNIT	262,605	0	262,605
43.00	04300	NURSERY	161,550	0	161,550
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	976,806	0	976,806
51.00	05100	RECOVERY ROOM	262,540	0	262,540
52.00	05200	DELIVERY ROOM & LABOR ROOM	220,296	0	220,296
53.00	05300	ANESTHESIOLOGY	27,389	0	27,389
53.01	05301	PAIN MANAGEMENT	37,418	0	37,418
54.00	05400	RADIOLOGY-DIAGNOSTIC	749,756	0	749,756
54.01	05401	ULTRASOUND	184,466	0	184,466
56.00	05600	RADIOISOTOPE	295,157	0	295,157
57.00	05700	CT SCAN	157,382	0	157,382
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	132,843	0	132,843
59.00	05900	CARDIAC CATHETERIZATION	699,927	0	699,927
60.00	06000	LABORATORY	735,906	0	735,906
65.00	06500	RESPIRATORY THERAPY	171,124	0	171,124
66.00	06600	PHYSICAL THERAPY	33,473	0	33,473
67.00	06700	OCCUPATIONAL THERAPY	8,651	0	8,651
68.00	06800	SPEECH PATHOLOGY	6,197	0	6,197
69.00	06900	ELECTROCARDIOLOGY	336,311	0	336,311
70.00	07000	ELECTROENCEPHALOGRAPHY	49,251	0	49,251
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	504,670	0	504,670
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	526,848	0	526,848
74.00	07400	RENAL DIALYSIS	5,906	0	5,906
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0
75.01	07501	GI LAB	198,661	0	198,661
76.00	03020	DIABETIC EDUCATION	21,846	0	21,846
76.01	03021	WOUND CARE	56,692	0	56,692
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	2,111,785	0	2,111,785
91.00	09100	EMERGENCY	330,443	0	330,443
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	195,070	0	195,070
98.00	05950	HOME INFUSION	10,357	0	10,357
101.00	10100	HOME HEALTH AGENCY	121,440	0	121,440
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,187,750	0	11,187,750
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19,206	0	19,206
192.00	19200	PHYSICIANS' PRIVATE OFFICES	229,218	0	229,218
194.00	07950	COMMUNITY SERVICE	55,309	0	55,309
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)	11,491,483	0	11,491,483

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet B-1

Date/Time Prepared:  
9/26/2014 5: 19 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	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	483,622				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		6,149,306			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	901	5,309	50,926,194		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	100,043	2,330,472	10,999,385	-27,899,633	105,152,109
7.00 00700	OPERATION OF PLANT	17,953	330,020	1,008,803	0	4,520,740
8.00 00800	LAUNDRY & LINEN SERVICE	7,117	28,251	277,128	0	649,832
9.00 00900	HOUSEKEEPING	740	2,179	895,516	0	2,047,685
10.00 01000	DIETARY	2,501	63,842	234,025	0	694,368
11.00 01100	CAFETERIA	6,749	0	631,470	0	971,592
13.00 01300	NURSING ADMINISTRATION	200	32,090	807,269	0	1,428,410
14.00 01400	CENTRAL SERVICES & SUPPLY	1,045	33,701	335,344	0	649,241
15.00 01500	PHARMACY	1,804	32,331	883,512	0	1,709,948
16.00 01600	MEDICAL RECORDS & LIBRARY	5,412	64,054	1,677,063	0	3,646,205
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	47,607	323,050	7,895,091	0	13,229,524
31.00 03100	INTENSIVE CARE UNIT	10,106	37,912	1,373,021	0	2,317,240
43.00 04300	NURSERY	8,620	24,388	445,084	0	820,943
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	24,348	492,270	1,180,077	0	2,840,217
51.00 05100	RECOVERY ROOM	13,508	37,785	845,750	0	1,500,411
52.00 05200	DELIVERY ROOM & LABOR ROOM	9,881	44,002	803,187	0	1,423,932
53.00 05300	ANESTHESIOLOGY	640	12,283	0	0	57,657
53.01 05301	PAIN MANAGEMENT	1,560	8,808	115,394	0	206,964
54.00 05400	RADIOLOGY-DIAGNOSTIC	17,414	405,778	1,380,647	0	3,056,392
54.01 05401	ULTRASOUND	2,922	110,671	441,374	0	889,865
56.00 05600	RADIOISOTOPE	6,886	175,939	279,225	0	738,519
57.00 05700	CT SCAN	1,892	66,007	609,112	0	1,297,570
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	4,017	49,321	323,894	0	767,365
59.00 05900	CARDIAC CATHETERIZATION	7,860	501,466	771,660	0	2,026,291
60.00 06000	LABORATORY	12,171	316,816	2,265,584	0	6,323,522
65.00 06500	RESPIRATORY THERAPY	5,214	53,294	802,865	0	1,465,982
66.00 06600	PHYSICAL THERAPY	984	3,697	276,813	0	452,520
67.00 06700	OCCUPATIONAL THERAPY	401	0	66,506	0	107,398
68.00 06800	SPEECH PATHOLOGY	120	0	84,113	0	135,389
69.00 06900	ELECTROCARDIOLOGY	4,022	215,773	797,877	0	1,559,613
70.00 07000	ELECTROENCEPHALOGRAPHY	1,311	17,770	171,421	0	328,579
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	12,890,203
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	11,902,113
74.00 07400	RENAL DIALYSIS	252	0	0	0	82,103
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
75.01 07501	GI LAB	3,863	80,062	897,990	0	1,608,403
76.00 03020	DIABETIC EDUCATION	1,555	313	26,586	0	68,895
76.01 03021	WOUND CARE	2,349	2,329	226,959	0	667,133
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	130,798	98,114	5,256,377	0	9,940,634
91.00 09100	EMERGENCY	7,937	39,169	2,677,438	0	4,378,612
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	2,368	69,278	1,481,292	0	2,514,374
98.00 05950	HOME INFUSION	210	0	52,901	0	212,712
101.00 10100	HOME HEALTH AGENCY	2,124	33,858	989,341	0	1,675,830
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	477,405	6,142,402	50,287,094	-27,899,633	103,804,926
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,267	1,372	12,721	0	66,279
192.00 19200	PHYSICIANS' PRIVATE OFFICES	2,502	0	298,539	0	724,522
194.00 07950	COMMUNITY SERVICE	2,448	5,532	327,840	0	556,382
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)	4,901,508	6,302,537	28,051,262		27,899,633
203.00	Unit cost multiplier (Wkst. B, Part I)	10.134998	1.024918	0.550822		0.265326
204.00	Cost to be allocated (per Wkst. B, Part II)			14,573		3,461,768
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000286		0.032922

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet B-1

Date/Time Prepared:  
9/26/2014 5:19 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700	364,725					7.00
8.00	00800	7,117	1,047,899				8.00
9.00	00900	740	56,501	356,868			9.00
10.00	01000	2,501	28,340	2,501	67,557		10.00
11.00	01100	6,749	0	6,749	0	81,174	11.00
13.00	01300	200	0	200	0	893	13.00
14.00	01400	1,045	0	1,045	0	822	14.00
15.00	01500	1,804	0	1,804	0	1,325	15.00
16.00	01600	5,412	0	5,412	0	4,103	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	47,607	499,653	47,607	62,883	16,620	30.00
31.00	03100	10,106	41,127	10,106	3,998	2,559	31.00
43.00	04300	8,620	7,101	8,620	0	642	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	24,348	42,899	24,348	0	1,876	50.00
51.00	05100	13,508	19,827	13,508	0	1,358	51.00
52.00	05200	9,881	12,811	9,881	0	1,159	52.00
53.00	05300	640	0	640	0	0	53.00
53.01	05301	1,560	0	1,560	0	210	53.01
54.00	05400	17,414	47,543	17,414	0	2,840	54.00
54.01	05401	2,922	0	2,922	0	672	54.01
56.00	05600	6,886	0	6,886	0	408	56.00
57.00	05700	1,892	0	1,892	0	1,002	57.00
58.00	05800	4,017	0	4,017	0	466	58.00
59.00	05900	7,860	21,970	7,860	210	1,200	59.00
60.00	06000	12,171	246	12,171	0	5,368	60.00
65.00	06500	5,214	10	5,214	0	1,407	65.00
66.00	06600	984	10,487	984	0	584	66.00
67.00	06700	401	0	401	0	74	67.00
68.00	06800	120	0	120	0	96	68.00
69.00	06900	4,022	11,560	4,022	0	1,679	69.00
70.00	07000	1,311	8,763	1,311	0	421	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	252	0	252	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	3,863	54,480	3,863	0	1,327	75.01
76.00	03020	1,555	0	1,555	0	56	76.00
76.01	03021	2,349	7,611	2,349	0	552	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	130,798	34,830	130,798	0	20,232	90.00
91.00	09100	7,937	85,985	7,937	466	4,995	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	2,368	35,997	2,368	0	3,437	95.00
98.00	05950	210	0	210	0	132	98.00
101.00	10100	2,124	0	2,124	0	1,539	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		358,508	1,027,741	350,651	67,557	80,054	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	1,267	0	1,267	0	88	190.00
192.00	19200	2,502	18,581	2,502	0	410	192.00
194.00	07950	2,448	1,577	2,448	0	622	194.00
200.00							200.00
201.00							201.00
202.00		5,720,210	933,869	2,652,948	961,675	1,385,402	202.00
203.00		15.683625	0.891182	7.433976	14.235016	17.067066	203.00
204.00		671,913	135,670	86,081	122,587	114,630	204.00
205.00		1.842246	0.129469	0.241212	1.814571	1.412152	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet B-1

Date/Time Prepared:  
9/26/2014 5:19 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300	1,130,559				13.00
14.00	01400	0	12,931,634			14.00
15.00	01500	0	0	11,902,113		15.00
16.00	01600	0	4	0	539,124,991	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	345,692	2,577	0	34,514,904	30.00
31.00	03100	53,229	2,053	0	7,169,692	31.00
43.00	04300	13,357	0	0	2,631,431	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	39,012	2,889	0	32,369,587	50.00
51.00	05100	28,252	3,995	0	5,272,158	51.00
52.00	05200	24,104	0	0	4,748,631	52.00
53.00	05300	0	0	0	10,611,878	53.00
53.01	05301	4,363	2,369	0	3,860,360	53.01
54.00	05400	0	0	0	20,690,560	54.00
54.01	05401	0	0	0	10,362,360	54.01
56.00	05600	0	0	0	11,957,004	56.00
57.00	05700	0	0	0	46,565,213	57.00
58.00	05800	0	0	0	15,027,643	58.00
59.00	05900	24,964	0	0	33,873,295	59.00
60.00	06000	0	0	0	96,431,354	60.00
65.00	06500	0	4,521	0	4,781,772	65.00
66.00	06600	0	4,715	0	993,733	66.00
67.00	06700	0	0	0	191,264	67.00
68.00	06800	0	0	0	238,564	68.00
69.00	06900	34,917	2,369	0	16,645,406	69.00
70.00	07000	0	0	0	2,969,677	70.00
71.00	07100	0	12,890,203	0	22,094,446	71.00
72.00	07200	0	0	0	0	72.00
73.00	07300	0	0	11,902,113	44,694,767	73.00
74.00	07400	0	0	0	259,448	74.00
75.00	07500	0	0	0	0	75.00
75.01	07501	0	2,699	0	15,141,870	75.01
76.00	03020	0	0	0	355,138	76.00
76.01	03021	0	0	0	3,780,077	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	420,825	5,969	0	38,244,398	90.00
91.00	09100	103,900	2,369	0	45,200,012	91.00
92.00	09200					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	0	570	0	5,040,169	95.00
98.00	05950	2,741	0	0	802,709	98.00
101.00	10100	32,021	2,614	0	1,605,471	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300					113.00
118.00		1,127,377	12,929,916	11,902,113	539,124,991	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	0	1,718	0	0	190.00
192.00	19200	0	0	0	0	192.00
194.00	07950	3,182	0	0	0	194.00
200.00						200.00
201.00						201.00
202.00		1,827,269	859,689	2,227,960	4,808,777	202.00
203.00		1.616253	0.066480	0.187190	0.008920	203.00
204.00		83,851	69,940	113,598	258,090	204.00
205.00		0.074168	0.005408	0.009544	0.000479	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet C  
Part I  
Date/Time Prepared:  
9/26/2014 5:19 pm

		Title XVIII		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	20,331,110		20,331,110	0	20,331,110	30.00
31.00	03100 INTENSIVE CARE UNIT	3,453,052		3,453,052	0	3,453,052	31.00
43.00	04300 NURSERY	1,300,380		1,300,380	0	1,300,380	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	4,578,898		4,578,898	0	4,578,898	50.00
51.00	05100 RECOVERY ROOM	2,344,583		2,344,583	0	2,344,583	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,142,677		2,142,677	0	2,142,677	52.00
53.00	05300 ANESTHESIOLOGY	182,409		182,409	0	182,409	53.00
53.01	05301 PAIN MANAGEMENT	343,167		343,167	0	343,167	53.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,545,301		4,545,301	0	4,545,301	54.00
54.01	05401 ULTRASOUND	1,297,420		1,297,420	0	1,297,420	54.01
56.00	05600 RADIOISOTOPE	1,207,273		1,207,273	0	1,207,273	56.00
57.00	05700 CT SCAN	2,118,050		2,118,050	0	2,118,050	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,205,830		1,205,830	0	1,205,830	58.00
59.00	05900 CARDIAC CATHETERIZATION	3,131,169		3,131,169	0	3,131,169	59.00
60.00	06000 LABORATORY	9,234,467		9,234,467	0	9,234,467	60.00
65.00	06500 RESPIRATORY THERAPY	2,042,456	0	2,042,456	0	2,042,456	65.00
66.00	06600 PHYSICAL THERAPY	623,823	0	623,823	0	623,823	66.00
67.00	06700 OCCUPATIONAL THERAPY	148,132	0	148,132	0	148,132	67.00
68.00	06800 SPEECH PATHOLOGY	177,851	0	177,851	0	177,851	68.00
69.00	06900 ELECTROCARDIOLOGY	2,310,425		2,310,425	0	2,310,425	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	487,551		487,551	0	487,551	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17,364,328		17,364,328	0	17,364,328	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	17,686,690		17,686,690	0	17,686,690	73.00
74.00	07400 RENAL DIALYSIS	112,026		112,026	0	112,026	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	07501 GI LAB	2,330,901		2,330,901	0	2,330,901	75.01
76.00	03020 DIABETIC EDUCATION	127,247		127,247	0	127,247	76.00
76.01	03021 WOUND CARE	948,366		948,366	0	948,366	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	16,999,919		16,999,919	0	16,999,919	90.00
91.00	09100 EMERGENCY	6,463,638		6,463,638	0	6,463,638	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3,365,109		3,365,109	0	3,365,109	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	3,371,982		3,371,982	0	3,371,982	95.00
98.00	05950 HOME INFUSION	287,848		287,848	0	287,848	98.00
101.00	10100 HOME HEALTH AGENCY	2,262,088		2,262,088	0	2,262,088	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	134,526,166	0	134,526,166	0	134,526,166	200.00
201.00	Less Observation Beds	3,365,109		3,365,109		3,365,109	201.00
202.00	Total (see instructions)	131,161,057	0	131,161,057	0	131,161,057	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140043		Period: From 05/01/2013 To 04/30/2014		Worksheet C Part I Date/Time Prepared: 9/26/2014 5:19 pm		
			Title XVIIII			Hospital		PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio				
	Inpatient	Outpatient	Total (col. 6 + col. 7)						
	6.00	7.00	8.00				9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	29,654,736		29,654,736				30.00
31.00	03100	INTENSIVE CARE UNIT	7,169,692		7,169,692				31.00
43.00	04300	NURSERY	2,631,431		2,631,431				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	12,732,273	19,637,314	32,369,587	0.141457	0.000000		50.00
51.00	05100	RECOVERY ROOM	1,210,713	4,061,445	5,272,158	0.444710	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,082,738	1,665,893	4,748,631	0.451220	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	5,019,706	5,592,172	10,611,878	0.017189	0.000000		53.00
53.01	05301	PAIN MANAGEMENT	877	3,859,483	3,860,360	0.088895	0.000000		53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,108,554	17,582,006	20,690,560	0.219680	0.000000		54.00
54.01	05401	ULTRASOUND	1,295,361	9,066,999	10,362,360	0.125205	0.000000		54.01
56.00	05600	RADIOISOTOPE	1,443,738	10,513,266	11,957,004	0.100968	0.000000		56.00
57.00	05700	CT SCAN	11,350,799	35,214,414	46,565,213	0.045486	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,547,422	13,480,221	15,027,643	0.080241	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	13,425,891	20,447,404	33,873,295	0.092438	0.000000		59.00
60.00	06000	LABORATORY	25,252,035	71,179,319	96,431,354	0.095762	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	3,435,920	1,345,852	4,781,772	0.427134	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	856,479	137,254	993,733	0.627757	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	95,666	95,598	191,264	0.774490	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	87,622	150,942	238,564	0.745506	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	4,586,636	12,058,770	16,645,406	0.138803	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	121,791	2,847,886	2,969,677	0.164176	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,590,047	10,504,399	22,094,446	0.785914	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,782,533	23,912,234	44,694,767	0.395722	0.000000		73.00
74.00	07400	RENAL DIALYSIS	247,345	12,103	259,448	0.431786	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000		75.00
75.01	07501	GI LAB	1,761,511	13,380,359	15,141,870	0.153937	0.000000		75.01
76.00	03020	DIABETIC EDUCATION	1,880	353,258	355,138	0.358303	0.000000		76.00
76.01	03021	WOUND CARE	20,856	3,759,221	3,780,077	0.250885	0.000000		76.01
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	94,147	38,150,251	38,244,398	0.444507	0.000000		90.00
91.00	09100	EMERGENCY	11,425,679	33,774,333	45,200,012	0.143001	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,092,045	3,768,123	4,860,168	0.692385	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	964	5,039,205	5,040,169	0.669022	0.000000		95.00
98.00	05950	HOME INFUSION	0	802,709	802,709	0.358596	0.000000		98.00
101.00	10100	HOME HEALTH AGENCY	0	1,605,471	1,605,471				101.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	175,127,087	363,997,904	539,124,991				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	175,127,087	363,997,904	539,124,991				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140043	Period: From 05/01/2013 To 04/30/2014	Worksheet C Part I Date/Time Prepared: 9/26/2014 5:19 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.141457		50.00
51.00	05100 RECOVERY ROOM	0.444710		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.451220		52.00
53.00	05300 ANESTHESIOLOGY	0.017189		53.00
53.01	05301 PAIN MANAGEMENT	0.088895		53.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.219680		54.00
54.01	05401 ULTRASOUND	0.125205		54.01
56.00	05600 RADIOISOTOPE	0.100968		56.00
57.00	05700 CT SCAN	0.045486		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.080241		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.092438		59.00
60.00	06000 LABORATORY	0.095762		60.00
65.00	06500 RESPIRATORY THERAPY	0.427134		65.00
66.00	06600 PHYSICAL THERAPY	0.627757		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.774490		67.00
68.00	06800 SPEECH PATHOLOGY	0.745506		68.00
69.00	06900 ELECTROCARDIOLOGY	0.138803		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.164176		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.785914		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.395722		73.00
74.00	07400 RENAL DIALYSIS	0.431786		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000		75.00
75.01	07501 GI LAB	0.153937		75.01
76.00	03020 DIABETIC EDUCATION	0.358303		76.00
76.01	03021 WOUND CARE	0.250885		76.01
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.444507		90.00
91.00	09100 EMERGENCY	0.143001		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.692385		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0.669022		95.00
98.00	05950 HOME INFUSION	0.358596		98.00
101.00	10100 HOME HEALTH AGENCY			101.00
	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: 140043		Period: From 05/01/2013 To 04/30/2014		Worksheet D Part I Date/Time Prepared: 9/26/2014 5:19 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) PPS	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,594,984	0	1,594,984	17,364	91.86	30.00
31.00	INTENSIVE CARE UNIT	262,605		262,605	1,501	174.95	31.00
43.00	NURSERY	161,550		161,550	984	164.18	43.00
200.00	Total (Lines 30-199)	2,019,139		2,019,139	19,849		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	8,344	766,480				
31.00	INTENSIVE CARE UNIT	1,016	177,749				
43.00	NURSERY	0	0				
200.00	Total (Lines 30-199)	9,360	944,229				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140043	Period: From 05/01/2013 To 04/30/2014	Worksheet D Part II Date/Time Prepared: 9/26/2014 5:19 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)	Hospital 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	976,806	32,369,587	0.030177	5,599,108	168,964	50.00
51.00	05100	RECOVERY ROOM	262,540	5,272,158	0.049797	536,691	26,726	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	220,296	4,748,631	0.046391	34,381	1,595	52.00
53.00	05300	ANESTHESIOLOGY	27,389	10,611,878	0.002581	2,254,338	5,818	53.00
53.01	05301	PAIN MANAGEMENT	37,418	3,860,360	0.009693	0	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	749,756	20,690,560	0.036237	1,940,399	70,314	54.00
54.01	05401	ULTRASOUND	184,466	10,362,360	0.017802	705,047	12,551	54.01
56.00	05600	RADIOISOTOPE	295,157	11,957,004	0.024685	874,576	21,589	56.00
57.00	05700	CT SCAN	157,382	46,565,213	0.003380	6,572,395	22,215	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	132,843	15,027,643	0.008840	813,871	7,195	58.00
59.00	05900	CARDIAC CATHETERIZATION	699,927	33,873,295	0.020663	7,184,599	148,455	59.00
60.00	06000	LABORATORY	735,906	96,431,354	0.007631	15,404,694	117,553	60.00
65.00	06500	RESPIRATORY THERAPY	171,124	4,781,772	0.035787	2,314,836	82,841	65.00
66.00	06600	PHYSICAL THERAPY	33,473	993,733	0.033684	599,314	20,187	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,651	191,264	0.045231	55,787	2,523	67.00
68.00	06800	SPEECH PATHOLOGY	6,197	238,564	0.025976	72,101	1,873	68.00
69.00	06900	ELECTROCARDIOLOGY	336,311	16,645,406	0.020204	2,965,399	59,913	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	49,251	2,969,677	0.016585	89,755	1,489	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	504,670	22,094,446	0.022841	6,485,812	148,142	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	526,848	44,694,767	0.011788	11,781,364	138,879	73.00
74.00	07400	RENAL DIALYSIS	5,906	259,448	0.022764	200,172	4,557	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	07501	GI LAB	198,661	15,141,870	0.013120	1,153,202	15,130	75.01
76.00	03020	DIABETIC EDUCATION	21,846	355,138	0.061514	386	24	76.00
76.01	03021	WOUND CARE	56,692	3,780,077	0.014998	7,405	111	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,111,785	38,244,398	0.055218	84,180	4,648	90.00
91.00	09100	EMERGENCY	330,443	45,200,012	0.007311	6,730,390	49,206	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	263,993	4,860,168	0.054318	603,959	32,806	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
98.00	05950	HOME INFUSION	10,357	802,709	0.012903	0	0	98.00
200.00		Total (Lines 50-199)	9,116,094	493,023,492		75,064,161	1,165,304	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140043		Period: From 05/01/2013 To 04/30/2014		Worksheet D Part III Date/Time Prepared: 9/26/2014 5:19 pm	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	PPS Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,364	0.00	8,344	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,501	0.00	1,016	0		31.00
43.00	04300	NURSERY	984	0.00	0	0		43.00
200.00		Total (lines 30-199)	19,849		9,360	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet D  
Part IV  
Date/Time Prepared:  
9/26/2014 5:19 pm

Cost Center Description		Title XVIII				Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)			
		1.00	2.00	3.00	4.00	5.00			
<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	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00	
53.01	05301	PAIN MANAGEMENT	0	0	0	0	0	53.01	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01	
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	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
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	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00	
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	
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00	
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00	
75.01	07501	GI LAB	0	0	0	0	0	75.01	
76.00	03020	DIABETIC EDUCATION	0	0	0	0	0	76.00	
76.01	03021	WOUND CARE	0	0	0	0	0	76.01	
<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	
<b>OTHER REIMBURSABLE COST CENTERS</b>									
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00	
98.00	05950	HOME INFUSION	0	0	0	0	0	98.00	
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: 140043	Period: From 05/01/2013 To 04/30/2014	Worksheet D Part IV Date/Time Prepared: 9/26/2014 5:19 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	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	32,369,587	0.000000	0.000000	5,599,108	50.00
51.00	05100	RECOVERY ROOM	0	5,272,158	0.000000	0.000000	536,691	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,748,631	0.000000	0.000000	34,381	52.00
53.00	05300	ANESTHESIOLOGY	0	10,611,878	0.000000	0.000000	2,254,338	53.00
53.01	05301	PAIN MANAGEMENT	0	3,860,360	0.000000	0.000000	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	20,690,560	0.000000	0.000000	1,940,399	54.00
54.01	05401	ULTRASOUND	0	10,362,360	0.000000	0.000000	705,047	54.01
56.00	05600	RADIOISOTOPE	0	11,957,004	0.000000	0.000000	874,576	56.00
57.00	05700	CT SCAN	0	46,565,213	0.000000	0.000000	6,572,395	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	15,027,643	0.000000	0.000000	813,871	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	33,873,295	0.000000	0.000000	7,184,599	59.00
60.00	06000	LABORATORY	0	96,431,354	0.000000	0.000000	15,404,694	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,781,772	0.000000	0.000000	2,314,836	65.00
66.00	06600	PHYSICAL THERAPY	0	993,733	0.000000	0.000000	599,314	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	191,264	0.000000	0.000000	55,787	67.00
68.00	06800	SPEECH PATHOLOGY	0	238,564	0.000000	0.000000	72,101	68.00
69.00	06900	ELECTROCARDIOLOGY	0	16,645,406	0.000000	0.000000	2,965,399	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,969,677	0.000000	0.000000	89,755	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	22,094,446	0.000000	0.000000	6,485,812	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	44,694,767	0.000000	0.000000	11,781,364	73.00
74.00	07400	RENAL DIALYSIS	0	259,448	0.000000	0.000000	200,172	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
75.01	07501	GI LAB	0	15,141,870	0.000000	0.000000	1,153,202	75.01
76.00	03020	DIABETIC EDUCATION	0	355,138	0.000000	0.000000	386	76.00
76.01	03021	WOUND CARE	0	3,780,077	0.000000	0.000000	7,405	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	38,244,398	0.000000	0.000000	84,180	90.00
91.00	09100	EMERGENCY	0	45,200,012	0.000000	0.000000	6,730,390	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	4,860,168	0.000000	0.000000	603,959	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	0.000000	0	95.00
98.00	05950	HOME INFUSION	0	802,709	0.000000	0.000000	0	98.00
200.00		Total (Lines 50-199)	0	493,023,492			75,064,161	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet D  
Part IV  
Date/Time Prepared:  
9/26/2014 5:19 pm

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XVIII Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	5,457,412	0	50.00
51.00	05100 RECOVERY ROOM	0	2,257,225	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	1,506,383	0	53.00
53.01	05301 PAIN MANAGEMENT	0	340	0	53.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	5,278,467	0	54.00
54.01	05401 ULTRASOUND	0	2,464,525	0	54.01
56.00	05600 RADIOISOTOPE	0	5,248,924	0	56.00
57.00	05700 CT SCAN	0	13,589,333	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	3,524,557	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	9,620,953	0	59.00
60.00	06000 LABORATORY	0	6,415,778	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	492,224	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	3,988,098	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	963,003	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,183,296	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	10,665,884	0	73.00
74.00	07400 RENAL DIALYSIS	0	12,103	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	75.00
75.01	07501 GI LAB	0	4,952,931	0	75.01
76.00	03020 DIABETIC EDUCATION	0	13,735	0	76.00
76.01	03021 WOUND CARE	0	1,837,021	0	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	10,700,538	0	90.00
91.00	09100 EMERGENCY	0	9,054,864	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,656,758	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0	0	0	95.00
98.00	05950 HOME INFUSION	0	0	0	98.00
200.00	Total (Lines 50-199)	0	103,884,352	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140043	Period: From 05/01/2013 To 04/30/2014	Worksheet D Part V Date/Time Prepared: 9/26/2014 5:19 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	0.141457	5,457,412	0	0	771,989	50.00
51.00	05100 RECOVERY ROOM	0.444710	2,257,225	0	0	1,003,811	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.451220	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.017189	1,506,383	0	0	25,893	53.00
53.01	05301 PAIN MANAGEMENT	0.088895	340	0	0	30	53.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.219680	5,278,467	0	0	1,159,574	54.00
54.01	05401 ULTRASOUND	0.125205	2,464,525	0	0	308,571	54.01
56.00	05600 RADIO SOTOP	0.100968	5,248,924	0	0	529,973	56.00
57.00	05700 CT SCAN	0.045486	13,589,333	0	0	618,124	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.080241	3,524,557	0	0	282,814	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.092438	9,620,953	0	0	889,342	59.00
60.00	06000 LABORATORY	0.095762	6,415,778	5,504	0	614,388	60.00
65.00	06500 RESPIRATORY THERAPY	0.427134	492,224	0	0	210,246	65.00
66.00	06600 PHYSICAL THERAPY	0.627757	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.774490	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.745506	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.138803	3,988,098	0	0	553,560	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.164176	963,003	0	0	158,102	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.785914	4,183,296	3,143	0	3,287,711	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.395722	10,665,884	0	95,098	4,220,725	73.00
74.00	07400 RENAL DIALYSIS	0.431786	12,103	0	0	5,226	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501 GI LAB	0.153937	4,952,931	0	0	762,439	75.01
76.00	03020 DIABETIC EDUCATION	0.358303	13,735	0	0	4,921	76.00
76.01	03021 WOUND CARE	0.250885	1,837,021	0	0	460,881	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.444507	10,700,538	34	0	4,756,464	90.00
91.00	09100 EMERGENCY	0.143001	9,054,864	0	0	1,294,855	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.692385	1,656,758	0	0	1,147,114	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0.669022	0	0	0	0	95.00
98.00	05950 HOME INFUSION	0.358596	0	0	0	0	98.00
200.00	Subtotal (see instructions)		103,884,352	8,681	95,098	23,066,753	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		103,884,352	8,681	95,098	23,066,753	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140043	Period: From 05/01/2013 To 04/30/2014	Worksheet D Part V Date/Time Prepared: 9/26/2014 5:19 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
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
53.01 05301 PAIN MANAGEMENT	0	0		53.01
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 05401 ULTRASOUND	0	0		54.01
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
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	527	0		60.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,470	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	37,632		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
75.01 07501 GI LAB	0	0		75.01
76.00 03020 DIABETIC EDUCATION	0	0		76.00
76.01 03021 WOUND CARE	0	0		76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	15	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00 09500 AMBULANCE SERVICES	0	0		95.00
98.00 05950 HOME INFUSION	0	0		98.00
200.00	Subtotal (see instructions)	3,012	37,632	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	3,012	37,632	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140043	Period: From 05/01/2013 To 04/30/2014	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 9/26/2014 5:19 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)		17,364	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		17,364	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		14,490	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)		8,344	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)		20,331,110	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)		20,331,110	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)		20,331,110	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,170.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		9,769,823	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		9,769,823	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140043		Period: From 05/01/2013 To 04/30/2014		Worksheet D-1		
Title XVIII		Hospital		PPS		Date/Time Prepared: 9/26/2014 5:19 pm		
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)			
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	0	42.00	
Intensive Care Type Inpatient Hospital Units							0	0.00
43.00 INTENSIVE CARE UNIT	3,453,052	1,501	2,300.50	1,016	2,337,308		43.00	
44.00 CORONARY CARE UNIT							44.00	
45.00 BURN INTENSIVE CARE UNIT							45.00	
46.00 SURGICAL INTENSIVE CARE UNIT							46.00	
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00	
Cost Center Description							1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					17,523,081		48.00	
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					29,630,212		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)					944,229		50.00	
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,165,304		51.00	
52.00 Total Program excludable cost (sum of lines 50 and 51)					2,109,533		52.00	
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					27,520,679		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)					2,874		87.00	
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,170.88		88.00	
89.00 Observation bed cost (line 87 x line 88) (see instructions)					3,365,109		89.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140043		Period: From 05/01/2013 To 04/30/2014		Worksheet D-1 Date/Time Prepared: 9/26/2014 5:19 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	1,594,984	20,331,110	0.078450	3,365,109	263,993	90.00
91.00	Nursing School cost	0	20,331,110	0.000000	3,365,109	0	91.00
92.00	Allied health cost	0	20,331,110	0.000000	3,365,109	0	92.00
93.00	All other Medical Education	0	20,331,110	0.000000	3,365,109	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140043	Period: From 05/01/2013 To 04/30/2014	Worksheet D-3 Date/Time Prepared: 9/26/2014 5:19 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		14,093,914	30.00
31.00	03100	INTENSIVE CARE UNIT		4,003,458	31.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.141457	5,599,108	792,033 50.00
51.00	05100	RECOVERY ROOM	0.444710	536,691	238,672 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.451220	34,381	15,513 52.00
53.00	05300	ANESTHESIOLOGY	0.017189	2,254,338	38,750 53.00
53.01	05301	PAIN MANAGEMENT	0.088895	0	0 53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.219680	1,940,399	426,267 54.00
54.01	05401	ULTRASOUND	0.125205	705,047	88,275 54.01
56.00	05600	RADIOISOTOPE	0.100968	874,576	88,304 56.00
57.00	05700	CT SCAN	0.045486	6,572,395	298,952 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.080241	813,871	65,306 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.092438	7,184,599	664,130 59.00
60.00	06000	LABORATORY	0.095762	15,404,694	1,475,184 60.00
65.00	06500	RESPIRATORY THERAPY	0.427134	2,314,836	988,745 65.00
66.00	06600	PHYSICAL THERAPY	0.627757	599,314	376,224 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.774490	55,787	43,206 67.00
68.00	06800	SPEECH PATHOLOGY	0.745506	72,101	53,752 68.00
69.00	06900	ELECTROCARDIOLOGY	0.138803	2,965,399	411,606 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.164176	89,755	14,736 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.785914	6,485,812	5,097,290 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.395722	11,781,364	4,662,145 73.00
74.00	07400	RENAL DIALYSIS	0.431786	200,172	86,431 74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0 75.00
75.01	07501	GI LAB	0.153937	1,153,202	177,520 75.01
76.00	03020	DIABETIC EDUCATION	0.358303	386	138 76.00
76.01	03021	WOUND CARE	0.250885	7,405	1,858 76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.444507	84,180	37,419 90.00
91.00	09100	EMERGENCY	0.143001	6,730,390	962,453 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.692385	603,959	418,172 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			
98.00	05950	HOME INFUSION	0.358596	0	0 98.00
200.00		Total (sum of lines 50-94 and 96-98)		75,064,161	17,523,081 200.00
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)		75,064,161	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140043	Period: From 05/01/2013 To 04/30/2014	Worksheet E Part A Date/Time Prepared: 9/26/2014 5:19 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)		7,594,203		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		10,230,624		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)		334,657		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)		85.13		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)		1.98		30.00
31.00	Percentage of Medicaid patient days (see instructions)		17.40		31.00
32.00	Sum of lines 30 and 31		19.38		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140043	Period: From 05/01/2013 To 04/30/2014	Worksheet E Part A Date/Time Prepared: 9/26/2014 5:19 pm	
		Title XVIII	Hospital		PPS
		0	before 1/1	on/after 1/1	2.00
33.00	Allowable disproportionate share percentage (see instructions)		5.35	1.01	33.00
34.00	Disproportionate share adjustment (see instructions)		543,125		34.00
			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)				9,378,057,716 35.00
35.01	Factor 3 (see instructions)				0.000094483 35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)				854,731 35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)				496,447 35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		496,447		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)		19,199,056		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		21,252,676		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		20,739,271		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		1,439,204		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		1,705		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)		22,180,180		59.00
60.00	Primary payer payments		3,784		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		22,176,396		61.00
62.00	Deductibles billed to program beneficiaries		2,172,096		62.00
63.00	Coinurance billed to program beneficiaries		24,400		63.00
64.00	Allowable bad debts (see instructions)		563,503		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		366,277		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		444,243		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		20,346,177		67.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140043	Period: From 05/01/2013 To 04/30/2014	Worksheet E Part A Date/Time Prepared: 9/26/2014 5:19 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)		22,392		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		-14,294		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)		20,354,275		71.00
71.01	Sequestration adjustment (see instructions)		407,086		71.01
72.00	Interim payments		19,907,598		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		39,591		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		288,282		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 REIMBURSEMENT SETTLEMENT		Provider CCN: 140043	Period: From 05/01/2013 To 04/30/2014	Worksheet E Part B Date/Time Prepared: 9/26/2014 5:19 pm
		Title XVII	Hospital	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		40,644	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		23,066,753	2.00
3.00	PPS payments		21,051,656	3.00
4.00	Outlier payment (see instructions)		247,550	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		40,644	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		103,779	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)		103,779	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)		103,779	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		63,135	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)		40,644	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)		21,299,206	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		629	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		4,674,012	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)		16,665,209	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)		16,665,209	30.00
31.00	Primary payer payments		3,974	31.00
32.00	Subtotal (line 30 minus line 31)		16,661,235	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)		620,070	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		403,046	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		482,978	36.00
37.00	Subtotal (see instructions)		17,064,281	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-108	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)		17,064,389	40.00
40.01	Sequestration adjustment (see instructions)		341,288	40.01
41.00	Interim payments		16,681,710	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		41,391	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet E-1  
Part I  
Date/Time Prepared:  
9/26/2014 5:19 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		19,960,373		16,677,486	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	12/23/2013	4,224	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	12/23/2013	52,775		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)		-52,775		4,224	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)		19,907,598		16,681,710	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		39,591		41,391	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		19,947,189		16,723,101	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: 140043  
Component CCN: 14U043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet E-1  
Part I  
Date/Time Prepared:  
9/26/2014 5:19 pm

Title XVIII Swing Beds - SNF PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		0		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		0	7.00
				Contractor Number	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: 140043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet E-1  
Part II  
Date/Time Prepared:  
9/26/2014 5:19 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			5,155 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			9,360 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			179 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			15,991 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			539,124,991 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			11,949,221 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)			854,366 8.00
9.00	Sequestration adjustment amount (see instructions)			17,087 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			837,279 10.00
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 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)			837,279 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 140043	Period:	Worksheet E-2
		Component CCN: 14U043	From 05/01/2013 To 04/30/2014	Date/Time Prepared: 9/26/2014 5:19 pm
		Title XVIII	Swing Beds - SNF	PPS
		Part A	Part B	
		1.00	2.00	
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 6 and 7, line 202 for Part B) (For CAH, see instructions)			3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	0	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	0	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	0	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	0	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	RURAL DEMONSTRATION PROJECT	0		16.50
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	0	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
20.00	Interim payments	0	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21	0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

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

Provider CCN: 140043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet G

Date/Time Prepared:  
9/26/2014 5:19 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	21,963,367	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	30,969,551	0	0	0	4.00
5.00	Other receivable	709,447	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,691,571	0	0	0	7.00
8.00	Prepaid expenses	2,000,470	0	0	0	8.00
9.00	Other current assets	1,580,426	0	0	0	9.00
10.00	Due from other funds	10,870,250	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	70,785,082	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	2,649,399	0	0	0	12.00
13.00	Land improvements	3,760,155	0	0	0	13.00
14.00	Accumulated depreciation	-1,845,091	0	0	0	14.00
15.00	Buildings	94,064,364	0	0	0	15.00
16.00	Accumulated depreciation	-52,663,123	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	499,038	0	0	0	19.00
20.00	Accumulated depreciation	-343,917	0	0	0	20.00
21.00	Automobiles and trucks	455,583	0	0	0	21.00
22.00	Accumulated depreciation	-393,422	0	0	0	22.00
23.00	Major movable equipment	54,849,053	0	0	0	23.00
24.00	Accumulated depreciation	-38,103,000	0	0	0	24.00
25.00	Minor equipment depreciable	7,677,249	0	0	0	25.00
26.00	Accumulated depreciation	-5,621,423	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	6,776,789	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	71,761,654	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	36,050,325	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	2,348,341	0	0	0	33.00
34.00	Other assets	623,865	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	39,022,531	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	181,569,267	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	4,167,491	0	0	0	37.00
38.00	Salaries, wages, and fees payable	11,863,869	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,885,126	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	0	0	0	0	43.00
44.00	Other current liabilities	13,330,121	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	32,246,607	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	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	24,963,259	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	24,963,259	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	57,209,866	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	124,359,401				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)	124,359,401	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	181,569,267	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet G-1

Date/Time Prepared:  
9/26/2014 5:19 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		112,639,807		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		11,719,594			2.00
3.00	Total (sum of line 1 and line 2)		124,359,401		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		124,359,401		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)		124,359,401		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 140043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
9/26/2014 5:19 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	35,506,566		35,506,566	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	35,506,566		35,506,566	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	7,169,692		7,169,692	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)	7,169,692		7,169,692	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	42,676,258		42,676,258	17.00
18.00	Ancillary services	141,283,816	331,922,721	473,206,537	18.00
19.00	Outpatient services	2,089,899	107,388,093	109,477,992	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		2,408,180	2,408,180	22.00
23.00	AMBULANCE SERVICES	964	5,039,205	5,040,169	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL CHARGES	0	1,415,467	1,415,467	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	186,050,937	448,173,666	634,224,603	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		173,556,513		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)		173,556,513		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140043

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet G-3

Date/Time Prepared:  
9/26/2014 5:19 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	634,224,603	1.00
2.00	Less contractual allowances and discounts on patients' accounts	451,726,692	2.00
3.00	Net patient revenues (line 1 minus line 2)	182,497,911	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	173,556,513	4.00
5.00	Net income from service to patients (line 3 minus line 4)	8,941,398	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	43,780	6.00
7.00	Income from investments	926,136	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	19,309	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	740,762	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	102,223	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	1,012,265	22.00
23.00	Governmental appropriations	0	23.00
24.00	MEANINGFUL USE AND OTHER MISC REVENUE	5,004,713	24.00
25.00	Total other income (sum of lines 6-24)	7,849,188	25.00
26.00	Total (line 5 plus line 25)	16,790,586	26.00
27.00	UNCONSOLIDATED SUBSIDIARY	4,849,378	27.00
27.01	LOSS ON SALE	221,614	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	5,070,992	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	11,719,594	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140043

Period: From 05/01/2013

Worksheet H

HHA CCN: 147562

To 04/30/2014

Date/Time Prepared: 9/26/2014 5:19 pm

Home Health Agency I

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	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00			0		0	0	1.00
2.00			0		0	0	2.00
3.00	0	0	0	0	0	0	3.00
4.00	0	0	0	0	0	0	4.00
5.00	109,579	0	20,009	0	151,406	280,994	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	715,733	0	0	0	0	715,733	6.00
7.00	140,610	0	37	0	0	140,647	7.00
8.00	0	0	0	5,865	0	5,865	8.00
9.00	3,565	0	0	0	0	3,565	9.00
10.00	0	0	0	0	0	0	10.00
11.00	19,854	0	0	0	0	19,854	11.00
12.00	0	0	0	0	0	0	12.00
13.00	0	0	0	0	3,448	3,448	13.00
14.00	0	0	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	0	0	0	0	0	0	15.00
16.00	0	0	0	0	0	0	16.00
17.00	0	0	0	0	0	0	17.00
18.00	0	0	0	0	0	0	18.00
19.00	0	0	0	0	0	0	19.00
20.00	0	0	0	0	0	0	20.00
21.00	0	0	0	0	0	0	21.00
22.00	0	0	0	0	0	0	22.00
23.00	0	0	0	0	0	0	23.00
24.00	989,341	0	20,046	5,865	154,854	1,170,106	24.00
	Reclassifi cation	Reclassifi ed Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	0	0	0	0			1.00
2.00	0	0	0	0			2.00
3.00	0	0	0	0			3.00
4.00	0	0	0	0			4.00
5.00	-91,195	189,799	-813	188,986			5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	0	715,733	0	715,733			6.00
7.00	0	140,647	0	140,647			7.00
8.00	0	5,865	0	5,865			8.00
9.00	0	3,565	0	3,565			9.00
10.00	0	0	0	0			10.00
11.00	0	19,854	0	19,854			11.00
12.00	0	0	0	0			12.00
13.00	-3,448	0	0	0			13.00
14.00	0	0	0	0			14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	0	0	0	0			15.00
16.00	0	0	0	0			16.00
17.00	0	0	0	0			17.00
18.00	0	0	0	0			18.00
19.00	0	0	0	0			19.00
20.00	0	0	0	0			20.00
21.00	0	0	0	0			21.00
22.00	0	0	0	0			22.00
23.00	0	0	0	0			23.00
24.00	-94,643	1,075,463	-813	1,074,650			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 140043	Period: From 05/01/2013 To 04/30/2014	Worksheet H-1 Part I Date/Time Prepared: 9/26/2014 5:19 pm
		HHA CCN: 147562	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)		
		Bldgs & Fixtures	Movable Equipment					
		1.00	2.00					3.00
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00	
2.00	Capital Related - Movable Equipment	0	0			0	2.00	
3.00	Plant Operation & Maintenance	0	0	0		0	3.00	
4.00	Transportation	0	0	0	0	0	4.00	
5.00	Administrative and General	188,986	0	0	0	188,986	5.00	
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	715,733	0	0	0	715,733	6.00	
7.00	Physical Therapy	140,647	0	0	0	140,647	7.00	
8.00	Occupational Therapy	5,865	0	0	0	5,865	8.00	
9.00	Speech Pathology	3,565	0	0	0	3,565	9.00	
10.00	Medical Social Services	0	0	0	0	0	10.00	
11.00	Home Health Aide	19,854	0	0	0	19,854	11.00	
12.00	Supplies (see instructions)	0	0	0	0	0	12.00	
13.00	Drugs	0	0	0	0	0	13.00	
14.00	DME	0	0	0	0	0	14.00	
<b>HHA NONREIMBURSABLE SERVICES</b>								
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	23.00	
24.00	Total (sum of lines 1-23)	1,074,650	0	0	0	1,074,650	24.00	
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	Capital Related - Bldg. & Fixtures						1.00	
2.00	Capital Related - Movable Equipment						2.00	
3.00	Plant Operation & Maintenance						3.00	
4.00	Transportation						4.00	
5.00	Administrative and General	188,986					5.00	
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	152,725	868,458				6.00	
7.00	Physical Therapy	30,012	170,659				7.00	
8.00	Occupational Therapy	1,251	7,116				8.00	
9.00	Speech Pathology	761	4,326				9.00	
10.00	Medical Social Services	0	0				10.00	
11.00	Home Health Aide	4,237	24,091				11.00	
12.00	Supplies (see instructions)	0	0				12.00	
13.00	Drugs	0	0				13.00	
14.00	DME	0	0				14.00	
<b>HHA NONREIMBURSABLE SERVICES</b>								
15.00	Home Dialysis Aide Services	0	0				15.00	
16.00	Respiratory Therapy	0	0				16.00	
17.00	Private Duty Nursing	0	0				17.00	
18.00	Clinic	0	0				18.00	
19.00	Health Promotion Activities	0	0				19.00	
20.00	Day Care Program	0	0				20.00	
21.00	Home Delivered Meals Program	0	0				21.00	
22.00	Homemaker Service	0	0				22.00	
23.00	All Others (specify)	0	0				23.00	
24.00	Total (sum of lines 1-23)		1,074,650				24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 140043

Period:

Worksheet H-1

HHA CCN: 147562

From 05/01/2013  
To 04/30/2014

Part II  
Date/Time Prepared:  
9/26/2014 5:19 pm

Home Health  
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	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-188,986	885,664 5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	0	0	0	0	0	715,733 6.00
7.00	Physical Therapy	0	0	0	0	0	140,647 7.00
8.00	Occupational Therapy	0	0	0	0	0	5,865 8.00
9.00	Speech Pathology	0	0	0	0	0	3,565 9.00
10.00	Medical Social Services	0	0	0	0	0	0 10.00
11.00	Home Health Aide	0	0	0	0	0	19,854 11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0 12.00
13.00	Drugs	0	0	0	0	0	0 13.00
14.00	DME	0	0	0	0	0	0 14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0 15.00
16.00	Respiratory Therapy	0	0	0	0	0	0 16.00
17.00	Private Duty Nursing	0	0	0	0	0	0 17.00
18.00	Clinic	0	0	0	0	0	0 18.00
19.00	Health Promotion Activities	0	0	0	0	0	0 19.00
20.00	Day Care Program	0	0	0	0	0	0 20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0 21.00
22.00	Homemaker Service	0	0	0	0	0	0 22.00
23.00	All Others (specify)	0	0	0	0	0	0 23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-188,986	885,664 24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		188,986 25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.213383 26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140043

Period: From 05/01/2013

Worksheet H-2

HHA CCN: 147562

To 04/30/2014

Part I  
Date/Time Prepared:  
9/26/2014 5:19 pm

Home Health Agency I

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Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDG & FIXT	MVBLE EQUIP				
		0	1.00				
1.00 Administrative and General	0	21,527	34,702	60,359	116,588	30,934	1.00
2.00 Skilled Nursing Care	868,458	0	0	394,241	1,262,699	335,026	2.00
3.00 Physical Therapy	170,659	0	0	77,451	248,110	65,830	3.00
4.00 Occupational Therapy	7,116	0	0	0	7,116	1,888	4.00
5.00 Speech Pathology	4,326	0	0	1,964	6,290	1,669	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	24,091	0	0	10,936	35,027	9,294	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	1,074,650	21,527	34,702	544,951	1,675,830	444,641	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
	7.00	8.00	9.00	10.00	11.00	13.00	
1.00 Administrative and General	33,312	0	15,790	0	26,266	51,754	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	33,312	0	15,790	0	26,266	51,754	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140043

Period: From 05/01/2013 To 04/30/2014

Worksheet H-2 Part I

HHA CCN: 147562

Date/Time Prepared: 9/26/2014 5:19 pm

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Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	174	0	14,321	289,139	0	289,139	1.00
2.00	Skilled Nursing Care	0	0	0	1,597,725	0	1,597,725	2.00
3.00	Physical Therapy	0	0	0	313,940	0	313,940	3.00
4.00	Occupational Therapy	0	0	0	9,004	0	9,004	4.00
5.00	Speech Pathology	0	0	0	7,959	0	7,959	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	44,321	0	44,321	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	174	0	14,321	2,262,088	0	2,262,088	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Allocated HHA A&G (see Part II)	Total HHA Costs					
		27.00	28.00					
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	234,149	1,831,874					2.00
3.00	Physical Therapy	46,009	359,949					3.00
4.00	Occupational Therapy	1,320	10,324					4.00
5.00	Speech Pathology	1,166	9,125					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	6,495	50,816					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
20.00	Total (sum of lines 1-19) (2)	289,139	2,262,088					20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.146552						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140043  
HHA CCN: 147562

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet H-2  
Part II  
Date/Time Prepared:  
9/26/2014 5:19 pm

Home Health Agency I

PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00					
1.00 Administrative and General	2,124	33,858	109,579	0	116,588	2,124	1.00
2.00 Skilled Nursing Care	0	0	715,733	0	1,262,699	0	2.00
3.00 Physical Therapy	0	0	140,610	0	248,110	0	3.00
4.00 Occupational Therapy	0	0	0	0	7,116	0	4.00
5.00 Speech Pathology	0	0	3,565	0	6,290	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	19,854	0	35,027	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	2,124	33,858	989,341		1,675,830	2,124	20.00
21.00 Total cost to be allocated	21,527	34,702	544,951		444,641	33,312	21.00
22.00 Unit cost multiplier	10.135122	1.024928	0.550822		0.265326	15.683616	22.00
Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
	8.00	9.00	10.00	11.00	13.00	14.00	
1.00 Administrative and General	0	2,124	0	1,539	32,021	2,614	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	2,124	0	1,539	32,021	2,614	20.00
21.00 Total cost to be allocated	0	15,790	0	26,266	51,754	174	21.00
22.00 Unit cost multiplier	0.000000	7.434087	0.000000	17.066927	1.616252	0.066565	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140043  
HHA CCN: 147562

Period:  
From 05/01/2013  
To 04/30/2014

Worksheet H-2  
Part II  
Date/Time Prepared:  
9/26/2014 5:19 pm  
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Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
	15.00	16.00		
1.00 Administrative and General	0	1,605,471		1.00
2.00 Skilled Nursing Care	0	0		2.00
3.00 Physical Therapy	0	0		3.00
4.00 Occupational Therapy	0	0		4.00
5.00 Speech Pathology	0	0		5.00
6.00 Medical Social Services	0	0		6.00
7.00 Home Health Aide	0	0		7.00
8.00 Supplies (see instructions)	0	0		8.00
9.00 Drugs	0	0		9.00
10.00 DME	0	0		10.00
11.00 Home Dialysis Aide Services	0	0		11.00
12.00 Respiratory Therapy	0	0		12.00
13.00 Private Duty Nursing	0	0		13.00
14.00 Clinic	0	0		14.00
15.00 Health Promotion Activities	0	0		15.00
16.00 Day Care Program	0	0		16.00
17.00 Home Delivered Meals Program	0	0		17.00
18.00 Homemaker Service	0	0		18.00
19.00 All Others (specify)	0	0		19.00
20.00 Total (sum of lines 1-19)	0	1,605,471		20.00
21.00 Total cost to be allocated	0	14,321		21.00
22.00 Unit cost multiplier	0.000000	0.008920		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 140043	Period: From 05/01/2013 To 04/30/2014	Worksheet H-3 Part I Date/Time Prepared: 9/26/2014 5:19 pm
		HHA CCN: 147562	Title XVIII	Home Health Agency I PPS

Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	1,831,874		1,831,874	5,626	325.61	1.00
2.00	Physical Therapy	3.00	359,949	0	359,949	1,692	212.74	2.00
3.00	Occupational Therapy	4.00	10,324	0	10,324	65	158.83	3.00
4.00	Speech Pathology	5.00	9,125	0	9,125	53	172.17	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	50,816		50,816	324	156.84	6.00
7.00	Total (sum of lines 1-6)		2,262,088	0	2,262,088	7,760		7.00

Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits		Ratio (col. 3 ÷ col. 4)
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
	0	1.00	2.00	3.00	4.00	5.00

Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	1,310	2,607		8.00
9.00	Physical Therapy		99914	383	547		9.00
10.00	Occupational Therapy		99914	40	28		10.00
11.00	Speech Pathology		99914	14	47		11.00
12.00	Medical Social Services		99914	0	0		12.00
13.00	Home Health Aide		99914	63	193		13.00
14.00	Total (sum of lines 8-13)			1,810	3,422		14.00

Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	0	6,851	6,851	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	86	86	217	0.396313	16.00

Cost Center Description	Part A	Program Visits		Cost of Services	Part B	
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
	6.00	7.00	8.00	9.00	10.00	11.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	1,310	2,607		426,549	848,865	1.00
2.00	Physical Therapy	383	547		81,479	116,369	2.00
3.00	Occupational Therapy	40	28		6,353	4,447	3.00
4.00	Speech Pathology	14	47		2,410	8,092	4.00
5.00	Medical Social Services	0	0		0	0	5.00
6.00	Home Health Aide	63	193		9,881	30,270	6.00
7.00	Total (sum of lines 1-6)	1,810	3,422		526,672	1,008,043	7.00
	Cost Center Description	6.00	7.00	8.00	9.00	10.00	11.00

Limitation Cost Computation							
8.00	Skilled Nursing Care						8.00
9.00	Physical Therapy						9.00
10.00	Occupational Therapy						10.00
11.00	Speech Pathology						11.00
12.00	Medical Social Services						12.00
13.00	Home Health Aide						13.00
14.00	Total (sum of lines 8-13)						14.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 140043 HHA CCN: 147562	Period: From 05/01/2013 To 04/30/2014	Worksheet H-3 Part I Date/Time Prepared: 9/26/2014 5:19 pm
				Title XVIII	Home Health Agency I	PPS
Cost Center Description	Program Covered Charges			Cost of Services		
	Part A	Part B				
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
	6.00	7.00	8.00	9.00	10.00	11.00
<b>Supplies and Drugs Cost Computations</b>						
15.00	Cost of Medical Supplies					15.00
16.00	Cost of Drugs	217	0		86	16.00
Cost Center Description		Total Program Cost (sum of col.s. 9-10)				
		12.00				
<b>PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION</b>						
<b>Cost Per Visit Computation</b>						
1.00	Skilled Nursing Care	1,275,414				1.00
2.00	Physical Therapy	197,848				2.00
3.00	Occupational Therapy	10,800				3.00
4.00	Speech Pathology	10,502				4.00
5.00	Medical Social Services	0				5.00
6.00	Home Health Aide	40,151				6.00
7.00	Total (sum of lines 1-6)	1,534,715				7.00
Cost Center Description						
		12.00				
<b>Limitation Cost Computation</b>						
8.00	Skilled Nursing Care					8.00
9.00	Physical Therapy					9.00
10.00	Occupational Therapy					10.00
11.00	Speech Pathology					11.00
12.00	Medical Social Services					12.00
13.00	Home Health Aide					13.00
14.00	Total (sum of lines 8-13)					14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140043

Period:

Worksheet H-3

HHA CCN: 147562

From 05/01/2013

Part II

To 04/30/2014

Date/Time Prepared:

Title XVIII

Home Health Agency I

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Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
<b>PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS</b>							
1.00 Physical Therapy	66.00	0.627757	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.774490	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.745506	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.785914	8,717	6,851	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.395722	217	86	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 140043 HHA CCN: 147562	Period: From 05/01/2013 To 04/30/2014	Worksheet H-4 Part I-II Date/Time Prepared: 9/26/2014 5:19 pm
		Title XVII I	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
<b>PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES</b>				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	86	0
2.00	Total charges	0	217	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount 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(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	217	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	131	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
<b>PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT</b>				
10.00	Total reasonable cost (see instructions)		0	86
11.00	Total PPS Reimbursement - Full Episodes without Outliers		303,189	563,161
12.00	Total PPS Reimbursement - Full Episodes with Outliers		10,317	5,937
13.00	Total PPS Reimbursement - LUPA Episodes		4,774	21,903
14.00	Total PPS Reimbursement - PEP Episodes		2,139	15,065
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		1,382	553
16.00	Total PPS Outlier Reimbursement - PEP Episodes		1,202	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)			0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		323,003	606,705
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		323,003	606,705
25.00	Coinsurance billed to program patients (from your records)			0
26.00	Net cost (line 24 minus line 25)		323,003	606,705
27.00	Reimbursable bad debts (from your records)			0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		323,003	606,705
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		323,003	606,705
31.01	Sequestration adjustment (see instructions)		6,462	12,134
32.00	Interim payments (see instructions)		316,541	594,657
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33		0	-86
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	0

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140043	Period: From 05/01/2013 To 04/30/2014	Worksheet H-5
	HHA CCN: 147562	Home Health Agency I	Date/Time Prepared: 9/26/2014 5:19 pm 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		316,541		594,657	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			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			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. H-4, Part II, column as appropriate, line 32)		316,541		594,657	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		86	6.02
7.00	Total Medicare program liability (see instructions)		316,541		594,571	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140043	Period: From 05/01/2013 To 04/30/2014	Worksheet L Parts I-III Date/Time Prepared: 9/26/2014 5:19 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		1,412,948	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		26,256	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)		43.81	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)		1,439,204	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