

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: 140100	Period: From 07/01/2013 To 06/30/2014	Worksheet 5 Parts I-III Date/Time Prepared: 11/20/2014 10:58 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/20/2014 Time: 10:58 am
Contractor use only	5. <input checked="" 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 MIDWESTERN REGIONAL MEDICAL CENTER (140100) for the cost reporting period beginning 07/01/2013 and ending 06/30/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 11/20/2014 Time: 10:58 am
 EXn2LNiSPiRed4:u4fjJ:zYTGryfq0
 D0m8U0Cv0ckFEJ.D5angXQ1jr24tTR
 Bn2w02TEtj0T2y5h
 PI: Date: 11/20/2014 Time: 10:58 am
 dDLjNoBj7EKVbm5jyJ183Mu1jmQga0
 6a:7t0qgy1je1zmzom1TPkwLka85ks
 1pgX0pgJtA0Kpa88

(Signed)

Officer or Administrator of Provider(s)

Title

Date

[Signature]
 CFO
 11/20/14

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	2,165	87,536	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
200.00 Total	0	2,165	87,536	0	0	200.00

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OMB NO. 0938-0050

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	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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ECR: Date: 11/20/2014 Time: 10:58 am
EXn2LNiSPiRed4:u4fjj:zyTGryfq0
D0m8U0Cv0ckFEJ.D5angxQ1jr24tTR
Bn2w02Tetj0T2y5h
PI: Date: 11/20/2014 Time: 10:58 am
dDLjNoBj7EKVbm5jy183Mu1jmQga0
6a:7t0qgy1je1zmzom1TPkwlka85ks
1pgX0pqtAOKpa88

(Signed)

Officer or Administrator of Provider(s)

Title

Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
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1.00 Hospital	0	2,165	87,536	0	0	1.00
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3.00 Subprovider - IRF	0	0	0	0	0	3.00
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200.00 Total	0	2,165	87,536	0	0	200.00

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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.

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(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	2,165	87,536	0	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
200.00 Total	0	2,165	87,536	0	0	200.00

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	1.00	2.00	3.00	4.00	
Hospital and Hospital Health Care Complex Address:					
1.00	Street: 2501 EMMAUS AVENUE		PO Box:		1.00
2.00	City: ZION		State: IL	Zip Code: 60099	County: LAKE
					2.00

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
						V	XVIII	XIX	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	

Hospital and Hospital-Based Component Identification:										
3.00	Hospital	MIDWESTERN REGIONAL MEDICAL CENTER	140100	29404	1	07/01/1967	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
20.00	Cost Reporting Period (mm/dd/yyyy)	1.00	2.00	
21.00	Type of Control (see instructions)	07/01/2013	06/30/2014	20.00

Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)									22.01
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					0	N			23.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140100	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part I Date/Time Prepared: 11/20/2014 10:57 am		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		Y/N 1.00	Y/N 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)				39.00	
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.				58.00	
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 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)				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		
61.02	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		
61.03	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		
61.04	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		
61.05	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		
61.06	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		
			Program Name 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 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

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20
		1.00				
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))
				1.00	2.00	3.00
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000 64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))
				1.00	2.00	3.00
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000 66.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet S-2
Part I
Date/Time Prepared:
11/20/2014 10:57 am

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
					1.00	2.00	3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00	
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	71.00	
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00	
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	76.00	
					1.00		
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00	
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00	
					V	XIX	
					1.00	2.00	
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00	
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.				0.00	97.00	
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106.00	

	V	XIX	
107.00	1.00	2.00	107.00
108.00	N		108.00

	Physical	Occupational	Speech	Respiratory	
109.00	1.00	2.00	3.00	4.00	109.00

Miscellaneous Cost Reporting Information

	1.00	2.00	3.00	
115.00				115.00
116.00				116.00
117.00				117.00
118.00				118.00

	Premiums	Losses	Insurance	
118.01	1.00	2.00	3.00	118.01
	3,925,030	0	0	

	1.00	2.00	
118.02	N		118.02

119.00	DO NOT USE THIS LINE			
120.00	N	N		119.00 120.00
121.00	N			121.00

Transplant Center Information

125.00	N			125.00
126.00				126.00
127.00				127.00
128.00				128.00
129.00				129.00
130.00				130.00
131.00				131.00
132.00				132.00
133.00				133.00
134.00				134.00

All Providers

140.00	Y	14H130		140.00
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140100	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part I Date/Time Prepared: 11/20/2014 10:57 am
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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: CANCER TREATMENT CENTERS OF AMERICA	Contractor's Name: NGS		Contractor's Number: 00131		141.00
142.00	Street: 1336 BASSWOOD ROAD	PO Box:	6775 W WA			142.00
143.00	City: SCHAUMBURG, IL 60173	State:	IL	Zip Code:	53214	143.00

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

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

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

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

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

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

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

		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
		Y/N		
		1.00		
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	Y		12.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		13.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	Y		14.00
		Y/N		
		1.00		
PS&R Data				
		Part A		Part B
Description		Y/N	Date	Y/N
0		1.00	2.00	3.00
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	09/02/2014	Y
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
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
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
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

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	1.00 N	2.00	3.00 N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			Y	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			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		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	COREY		RUTLEDGE	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	612-376-4500		COREY.RUTLEDGE@CLACONNECT.COM	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	09/02/2014	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	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PRINCIPAL	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

		Title V 1.00	Title XIX 2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on w/s B, Part I, column 25? Enter Y/N in column 1 for Title v and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on w/s C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title v and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on w/s D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient 1.00	Outpatient 2.00	
CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title v 1.00	Title XIX 2.00	
RCE DISALLOWANCE				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on w/s C, Part I column 4? Enter Y/N in column 1 for Title v and Y/N in column 2 for Title XIX.	Y	Y	6.00
PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title v and Y/N in column 2 for Title XIX.	Y	Y	7.00

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	53	19,345	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)		53	19,345	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	34.00	12	4,380	0.00	0	11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		73	26,645	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						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)		73				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

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	834	23	8,801			1.00
2.00 HMO and other (see instructions)	0	0				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)	834	23	8,801			7.00
8.00 INTENSIVE CARE UNIT	127	1	1,543			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT	87	0	2,000			11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	1,048	24	12,344	0.00	1,224.86	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						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	1,224.86	27.00
28.00 Observation Bed Days		2	1,032			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

Component	Full Time	Discharges				Total All Patients	
	Equivalent _s	Title V	Title XVIII	Title XIX			
	Nonpaid worker _s	12.00	13.00	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	143	5	1,887	1.00	
2.00 HMO and other (see instructions)			0	0		2.00	
3.00 HMO IPF Subprovider						3.00	
4.00 HMO IRF Subprovider						4.00	
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00	
6.00 Hospital Adults & Peds. Swing Bed NF						6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00	
8.00 INTENSIVE CARE UNIT						8.00	
9.00 CORONARY CARE UNIT						9.00	
10.00 BURN INTENSIVE CARE UNIT						10.00	
11.00 SURGICAL INTENSIVE CARE UNIT						11.00	
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00	
13.00 NURSERY						13.00	
14.00 Total (see instructions)						14.00	
15.00 CAH visits	0.00	0	143	5	1,887	15.00	
16.00 SUBPROVIDER - IPF						16.00	
17.00 SUBPROVIDER - IRF						17.00	
18.00 SUBPROVIDER						18.00	
19.00 SKILLED NURSING FACILITY						19.00	
20.00 NURSING FACILITY						20.00	
21.00 OTHER LONG TERM CARE						21.00	
22.00 HOME HEALTH AGENCY						22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00	
24.00 HOSPICE						24.00	
24.10 HOSPICE (non-distinct part)						24.10	
25.00 CMHC - CMHC						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: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet S-3
Part II
Date/Time Prepared:
11/20/2014 10:57 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	77,414,279	0	77,414,279	2,547,705.83	30.39
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		6,908,510	1,014,578	7,923,088	310,553.11	25.51
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		609,007	0	609,007	9,578.25	63.58
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		175,628	0	175,628	2,153.00	81.57
14.00	Home office salaries & wage-related costs		32,615,426	0	32,615,426	287,258.00	113.54
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		22,473,800	0	22,473,800		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		3,119,728	0	3,119,728		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	8,088,985	-6,844,175	1,244,810	25,615.79	48.60
27.00	Administrative & General	5.00	6,705,053	857,864	7,562,917	253,198.29	29.87
28.00	Administrative & General under contract (see inst.)		456,684	0	456,684	1,347.00	339.04
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	1,502,689	132,977	1,635,666	64,452.97	25.38
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00
32.00	Housekeeping	9.00	1,313,702	116,253	1,429,955	87,533.71	16.34
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	1,894,240	-1,624,007	270,233	16,384.13	16.49
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	1,791,633	1,791,633	108,625.87	16.49
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	1,031,789	91,306	1,123,095	33,528.36	33.50
39.00	Central Services and Supply	14.00	431,601	38,194	469,795	22,383.45	20.99
40.00	Pharmacy	15.00	2,610,471	231,008	2,841,479	75,661.35	37.56

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet S-3
Part II
Date/Time Prepared:
11/20/2014 10:57 am

		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	2,702,839	239,181	2,942,020	105,186.20	27.97	41.00
42.00	Social Service	17.00	874,358	119,027	993,385	38,447.67	25.84	42.00
43.00	Other General Service	18.00	6,892,178	609,907	7,502,085	210,186.98	35.69	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet S-3
Part III
Date/Time Prepared:
11/20/2014 10:57 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	77,870,963	0	77,870,963	2,549,052.83	30.55	1.00
2.00	Excluded area salaries (see instructions)	6,908,510	1,014,578	7,923,088	310,553.11	25.51	2.00
3.00	Subtotal salaries (line 1 minus line 2)	70,962,453	-1,014,578	69,947,875	2,238,499.72	31.25	3.00
4.00	Subtotal other wages & related costs (see inst.)	33,400,061	0	33,400,061	298,989.25	111.71	4.00
5.00	Subtotal wage-related costs (see inst.)	22,473,800	0	22,473,800	0.00	32.13	5.00
6.00	Total (sum of lines 3 thru 5)	126,836,314	-1,014,578	125,821,736	2,537,488.97	49.59	6.00
7.00	Total overhead cost (see instructions)	34,504,589	-4,240,832	30,263,757	1,042,551.77	29.03	7.00

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet S-3
Part IV
Date/Time Prepared:
11/20/2014 10:57 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions		
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	1,593,670	1.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	2.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	3.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		0	4.00
5.00	401K/TSA Plan Administration fees		
6.00	Legal/Accounting/Management Fees-Pension Plan	0	5.00
7.00	Employee Managed Care Program Administration Fees	0	6.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)		
9.00	Prescription Drug Plan	10,054,230	8.00
10.00	Dental, Hearing and Vision Plan	2,464,813	9.00
11.00	Life Insurance (If employee is owner or beneficiary)	1,017,695	10.00
12.00	Accident Insurance (If employee is owner or beneficiary)	92,200	11.00
13.00	Disability Insurance (If employee is owner or beneficiary)	526,595	12.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	958,086	13.00
15.00	'workers' Compensation Insurance	12,724	14.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	367,486	15.00
		0	16.00
TAXES			
17.00	FICA-Employers Portion Only		
18.00	Medicare Taxes - Employers Portion Only	4,431,754	17.00
19.00	Unemployment Insurance	0	18.00
20.00	State or Federal Unemployment Taxes	0	19.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	476,643	20.00
		0	21.00
22.00	Day Care Cost and Allowances		
23.00	Tuition Reimbursement	0	22.00
24.00	Total wage Related cost (Sum of lines 1 -23)	477,904	23.00
Part B - Other than Core Related Cost		22,473,800	24.00
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		
		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet S-3
Part V
Date/Time Prepared:
11/20/2014 10:57 am

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

				1.00		
Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.239904	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			567,822	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?				3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			0	5.00	
6.00	Medicaid charges			2,809,411	6.00	
7.00	Medicaid cost (line 1 times line 6)			673,989	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)			106,167	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone SCHIP			0	9.00	
10.00	Stand-alone SCHIP charges			0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)			0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00	
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00	
Uncompensated care (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			106,167	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			2,669,927	27,290,123	29,960,050
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)			640,526	6,547,010	7,187,536
22.00	Partial payment by patients approved for charity care			0	0	0
23.00	Cost of charity care (line 21 minus line 22)			640,526	6,547,010	7,187,536
				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)					15,151,757
27.00	Medicare bad debts for the entire hospital complex (see instructions)					116,614
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)					15,035,143
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)					3,606,991
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)					10,794,527
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)					10,900,694

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet A

Date/Time Prepared:
11/20/2014 10:57 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		13,973,883	13,973,883	-70,242	13,903,641	1.00
2.00	00200		11,724,230	11,724,230	0	11,724,230	2.00
4.00	00400						
5.00	00500	8,088,985	18,288,309	26,377,294	-6,061,620	20,315,674	4.00
6.00	00600	6,705,053	328,186,656	334,891,709	-421,159	334,470,550	5.00
7.00	00700						
8.00	00800	1,502,689	6,225,165	7,727,854	132,977	7,860,831	6.00
9.00	00900						
10.00	01000						
11.00	01100						
13.00	01300						
14.00	01400	1,313,702	946,928	2,260,630	116,253	2,376,883	7.00
15.00	01500	1,894,240	4,029,650	5,923,890	-5,125,521	798,369	8.00
16.00	01600						
17.00	01700						
18.00	01850						
30.00	03000						
31.00	03100						
34.00	03400						
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	7,510,420	1,663,617	9,174,037	664,617	9,838,654	30.00
31.00	03100	1,878,085	249,050	2,127,135	166,197	2,293,332	31.00
34.00	03400	1,799,609	251,722	2,051,331	159,252	2,210,583	34.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,942,565	2,197,108	6,139,673	348,888	6,488,561	50.00
54.00	05400	3,242,283	1,612,261	4,854,544	286,918	5,141,462	54.00
55.00	05500	2,069,274	3,232,371	5,301,645	183,116	5,484,761	55.00
56.00	05600	401,441	69,901	471,342	35,525	506,867	56.00
57.00	05700	533,278	266,949	800,227	47,191	847,418	57.00
58.00	05800	403,572	251,109	654,681	35,713	690,394	58.00
60.00	06000	2,949,236	6,118,837	9,068,073	260,986	9,329,059	60.00
63.00	06300		1,844,796	1,844,796	0	1,844,796	63.00
64.00	06400	2,116,080	346,005	2,462,085	187,258	2,649,343	64.00
65.00	06500	791,136	167,661	958,797	70,010	1,028,807	65.00
66.00	06600	1,035,266	503,013	1,538,279	91,613	1,629,892	66.00
69.00	06900	370,970	80,373	451,343	32,828	484,171	69.00
70.00	07000						
71.00	07100						
72.00	07200		16,816,422	16,816,422	0	16,816,422	71.00
73.00	07300						
76.00	07600		79,519,103	79,519,103	0	79,519,103	72.00
76.01	03951						
76.02	03952	937,727	166,668	1,104,395	82,982	1,187,377	73.00
76.03	03954						
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	5,448,611	1,180,115	6,628,726	482,162	7,110,888	76.00
91.00	09100	1,028,311	1,564,725	2,593,036	90,998	2,684,034	76.01
92.00	09200						76.02
SPECIAL PURPOSE COST CENTERS							
113.00	11300		470,891	470,891	-396,877	74,014	76.03
118.00		70,505,769	506,506,791	577,012,560	-1,866,172	575,146,388	113.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	70,565	181,158	251,723	6,244	257,967	118.00
191.00	19100	407,081	95,255	502,336	36,024	538,360	190.00
194.00	07950	6,430,864	38,985,019	45,415,883	1,823,904	47,239,787	191.00
200.00		77,414,279	545,768,223	623,182,502	0	623,182,502	194.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet A

Date/Time Prepared:
11/20/2014 10:57 am

Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	-6,013,240	7,890,401	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	732,375	12,456,605	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-364,137	19,951,537	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-268,637,310	65,833,240	5.00
6.00	00600 MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700 OPERATION OF PLANT	0	7,860,831	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	183,300	8.00
9.00	00900 HOUSEKEEPING	-10,862	2,366,021	9.00
10.00	01000 DIETARY	-832	797,537	10.00
11.00	01100 CAFETERIA	-4,354,467	938,680	11.00
13.00	01300 NURSING ADMINISTRATION	-12	1,598,847	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	1,063,380	14.00
15.00	01500 PHARMACY	0	3,322,003	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-4,552	3,539,224	16.00
17.00	01700 SOCIAL SERVICE	-73,340	1,574,976	17.00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	-228,466	8,955,025	18.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-2,322	9,836,332	30.00
31.00	03100 INTENSIVE CARE UNIT	0	2,293,332	31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	2,210,583	34.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-93	6,488,468	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	-58	5,141,404	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	5,484,761	55.00
56.00	05600 RADIOISOTOPE	0	506,867	56.00
57.00	05700 CT SCAN	0	847,418	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	690,394	58.00
60.00	06000 LABORATORY	-46	9,329,013	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	1,844,796	63.00
64.00	06400 INTRAVENOUS THERAPY	0	2,649,343	64.00
65.00	06500 RESPIRATORY THERAPY	0	1,028,807	65.00
66.00	06600 PHYSICAL THERAPY	0	1,629,892	66.00
69.00	06900 ELECTROCARDIOLOGY	0	484,171	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	16,816,422	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	79,519,103	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.01	03951 HOSPITAL NUTRITION	-20	1,187,357	76.01
76.02	03952 PAIN MANAGEMENT	0	0	76.02
76.03	03954 INFUSION CENTER	0	0	76.03
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	-95	7,110,793	90.00
91.00	09100 EMERGENCY	-1,253,538	1,430,496	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE	-74,014	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-280,285,029	294,861,359	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	257,967	190.00
191.00	19100 RESEARCH	0	538,360	191.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	47,239,787	194.00
200.00	TOTAL (SUM OF LINES 118-199)	-280,285,029	342,897,473	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet Non-CMS W

Date/Time Prepared:
11/20/2014 10:57 am

Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00
GENERAL SERVICE COST CENTERS			
1.00 CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00 EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00 ADMINISTRATIVE & GENERAL	00500		5.00
6.00 MAINTENANCE & REPAIRS	00600		6.00
7.00 OPERATION OF PLANT	00700		7.00
8.00 LAUNDRY & LINEN SERVICE	00800		8.00
9.00 HOUSEKEEPING	00900		9.00
10.00 DIETARY	01000		10.00
11.00 CAFETERIA	01100		11.00
13.00 NURSING ADMINISTRATION	01300		13.00
14.00 CENTRAL SERVICES & SUPPLY	01400		14.00
15.00 PHARMACY	01500		15.00
16.00 MEDICAL RECORDS & LIBRARY	01600		16.00
17.00 SOCIAL SERVICE	01700		17.00
18.00 OTHER GENERAL SERVICE (SPECIFY)	01850		18.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS	03000		30.00
31.00 INTENSIVE CARE UNIT	03100		31.00
34.00 SURGICAL INTENSIVE CARE UNIT	03400		34.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	05000		50.00
54.00 RADIOLOGY-DIAGNOSTIC	05400		54.00
55.00 RADIOLOGY-THERAPEUTIC	05500		55.00
56.00 RADIOISOTOPE	05600		56.00
57.00 CT SCAN	05700		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
60.00 LABORATORY	06000		60.00
63.00 BLOOD STORING, PROCESSING & TRANS.	06300		63.00
64.00 INTRAVENOUS THERAPY	06400		64.00
65.00 RESPIRATORY THERAPY	06500		65.00
66.00 PHYSICAL THERAPY	06600		66.00
69.00 ELECTROCARDIOLOGY	06900		69.00
70.00 ELECTROENCEPHALOGRAPHY	07000		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00 DRUGS CHARGED TO PATIENTS	07300		73.00
76.00 OTHER ANCILLARY SERVICE COST CENTERS	03950		76.00
76.01 HOSPITAL NUTRITION	03951		76.01
76.02 PAIN MANAGEMENT	03952		76.02
76.03 INFUSION CENTER	03954		76.03
OUTPATIENT SERVICE COST CENTERS			
90.00 CLINIC	09000		90.00
91.00 EMERGENCY	09100		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
SPECIAL PURPOSE COST CENTERS			
113.00 INTEREST EXPENSE	11300		113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS			
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
191.00 RESEARCH	19100		191.00
194.00 OTHER NONREIMBURSABLE COST CENTERS	07950		194.00
200.00 TOTAL (SUM OF LINES 118-199)			200.00

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - RECLASS CAFETERIA					
1.00	CAFETERIA	11.00	1,791,633	3,501,514	1.00
	TOTALS		1,791,633	3,501,514	
B - EMPLOYEE BONUS					
1.00	ADMINISTRATIVE & GENERAL	5.00	1,254,149	0	1.00
2.00	OPERATION OF PLANT	7.00	132,977	0	2.00
3.00	HOUSEKEEPING	9.00	116,253	0	3.00
4.00	DIETARY	10.00	167,626	0	4.00
5.00	NURSING ADMINISTRATION	13.00	91,306	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	38,194	0	6.00
7.00	PHARMACY	15.00	231,008	0	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	239,181	0	8.00
9.00	SOCIAL SERVICE	17.00	77,374	0	9.00
10.00	OTHER GENERAL SERVICE (SPECIFY)	18.00	609,907	0	10.00
11.00	ADULTS & PEDIATRICS	30.00	664,617	0	11.00
12.00	INTENSIVE CARE UNIT	31.00	166,197	0	12.00
13.00	SURGICAL INTENSIVE CARE UNIT	34.00	159,252	0	13.00
14.00	OPERATING ROOM	50.00	348,888	0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	286,918	0	15.00
16.00	RADIOLOGY-THERAPEUTIC	55.00	183,116	0	16.00
17.00	RADIOISOTOPE	56.00	35,525	0	17.00
18.00	CT SCAN	57.00	47,191	0	18.00
19.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	35,713	0	19.00
20.00	LABORATORY	60.00	260,986	0	20.00
21.00	INTRAVENOUS THERAPY	64.00	187,258	0	21.00
22.00	RESPIRATORY THERAPY	65.00	70,010	0	22.00
23.00	PHYSICAL THERAPY	66.00	91,613	0	23.00
24.00	ELECTROCARDIOLOGY	69.00	32,828	0	24.00
25.00	HOSPITAL NUTRITION	76.01	82,982	0	25.00
26.00	CLINIC	90.00	482,162	0	26.00
27.00	EMERGENCY	91.00	90,998	0	27.00
28.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	6,244	0	28.00
29.00	RESEARCH	191.00	36,024	0	29.00
30.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	617,678	0	30.00
	TOTALS		6,844,175	0	
C - PROPERTY TAX					
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	0	991,725	1.00
	TOTALS		0	991,725	
D - TRAVEL/SCHEDULING					
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	481,888	63,544	1.00
	TOTALS		481,888	63,544	
E - GUEST SERVICES					
1.00	SOCIAL SERVICE	17.00	41,653	111,993	1.00
	TOTALS		41,653	111,993	
F - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	396,877	1.00
	TOTALS		0	396,877	
G - INSURANCE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	524,606	1.00
2.00	EMPLOYEE BENEFITS	4.00	0	782,555	2.00
	TOTALS		0	1,307,161	
H - TRANSPORTATION					
1.00	ADMINISTRATIVE & GENERAL	5.00	85,603	91,682	1.00
	TOTALS		85,603	91,682	
500.00	Grand Total: Increases		9,244,952	6,464,496	500.00

		Decreases				
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - RECLASS CAFETERIA						
1.00	DIETARY	10.00	1,791,633	3,501,514	0	1.00
	TOTALS		1,791,633	3,501,514		
B - EMPLOYEE BONUS						
1.00	EMPLOYEE BENEFITS	4.00	6,844,175	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
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
16.00		0.00	0	0	0	16.00
17.00		0.00	0	0	0	17.00
18.00		0.00	0	0	0	18.00
19.00		0.00	0	0	0	19.00
20.00		0.00	0	0	0	20.00
21.00		0.00	0	0	0	21.00
22.00		0.00	0	0	0	22.00
23.00		0.00	0	0	0	23.00
24.00		0.00	0	0	0	24.00
25.00		0.00	0	0	0	25.00
26.00		0.00	0	0	0	26.00
27.00		0.00	0	0	0	27.00
28.00		0.00	0	0	0	28.00
29.00		0.00	0	0	0	29.00
30.00		0.00	0	0	0	30.00
	TOTALS		6,844,175	0		
C - PROPERTY TAX						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	991,725	13	1.00
	TOTALS		0	991,725		
D - TRAVEL/SCHEDULING						
1.00	ADMINISTRATIVE & GENERAL	5.00	481,888	63,544	0	1.00
	TOTALS		481,888	63,544		
E - GUEST SERVICES						
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	41,653	111,993	0	1.00
	TOTALS		41,653	111,993		
F - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	396,877	11	1.00
	TOTALS		0	396,877		
G - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,307,161	12	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	1,307,161		
H - TRANSPORTATION						
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	85,603	91,682	0	1.00
	TOTALS		85,603	91,682		
500.00	Grand Total: Decreases		9,244,952	6,464,496		500.00

Increases			Decreases			
Cost Center	Line #	Salary	Cost Center	Line #	Salary	
2.00	3.00	4.00	6.00	7.00	8.00	
A - RECLASS CAFETERIA						
1.00	CAFETERIA	11.00	1,791,633	DIETARY	10.00	1,791,633
	TOTALS		1,791,633	TOTALS		1,791,633
B - EMPLOYEE BONUS						
1.00	ADMINISTRATIVE & GENERAL	5.00	1,254,149	EMPLOYEE BENEFITS	4.00	6,844,175
2.00	OPERATION OF PLANT	7.00	132,977		0.00	0
3.00	HOUSEKEEPING	9.00	116,253		0.00	0
4.00	DIETARY	10.00	167,626		0.00	0
5.00	NURSING ADMINISTRATION	13.00	91,306		0.00	0
6.00	CENTRAL SERVICES & SUPPLY	14.00	38,194		0.00	0
7.00	PHARMACY	15.00	231,008		0.00	0
8.00	MEDICAL RECORDS & LIBRARY	16.00	239,181		0.00	0
9.00	SOCIAL SERVICE	17.00	77,374		0.00	0
10.00	OTHER GENERAL SERVICE (SPECIFY)	18.00	609,907		0.00	0
11.00	ADULTS & PEDIATRICS	30.00	664,617		0.00	0
12.00	INTENSIVE CARE UNIT	31.00	166,197		0.00	0
13.00	SURGICAL INTENSIVE CARE UNIT	34.00	159,252		0.00	0
14.00	OPERATING ROOM	50.00	348,888		0.00	0
15.00	RADIOLOGY-DIAGNOSTIC	54.00	286,918		0.00	0
16.00	RADIOLOGY-THERAPEUTIC	55.00	183,116		0.00	0
17.00	RADIOISOTOPE	56.00	35,525		0.00	0
18.00	CT SCAN	57.00	47,191		0.00	0
19.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	35,713		0.00	0
20.00	LABORATORY	60.00	260,986		0.00	0
21.00	INTRAVENOUS THERAPY	64.00	187,258		0.00	0
22.00	RESPIRATORY THERAPY	65.00	70,010		0.00	0
23.00	PHYSICAL THERAPY	66.00	91,613		0.00	0
24.00	ELECTROCARDIOLOGY	69.00	32,828		0.00	0
25.00	HOSPITAL NUTRITION	76.01	82,982		0.00	0
26.00	CLINIC	90.00	482,162		0.00	0
27.00	EMERGENCY	91.00	90,998		0.00	0
28.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	6,244		0.00	0
29.00	RESEARCH	191.00	36,024		0.00	0
30.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	617,678		0.00	0
	TOTALS		6,844,175	TOTALS		6,844,175
C - PROPERTY TAX						
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	0	CAP REL COSTS-BLDG & FIXT	1.00	0
	TOTALS		0	TOTALS		0
D - TRAVEL/SCHEDULING						
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	481,888	ADMINISTRATIVE & GENERAL	5.00	481,888
	TOTALS		481,888	TOTALS		481,888
E - GUEST SERVICES						
1.00	SOCIAL SERVICE	17.00	41,653	OTHER NONREIMBURSABLE COST CENTERS	194.00	41,653
	TOTALS		41,653	TOTALS		41,653
F - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	INTEREST EXPENSE	113.00	0
	TOTALS		0	TOTALS		0
G - INSURANCE EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	ADMINISTRATIVE & GENERAL	5.00	0
2.00	EMPLOYEE BENEFITS	4.00	0		0.00	0
	TOTALS		0	TOTALS		0
H - TRANSPORTATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	85,603	OTHER NONREIMBURSABLE COST CENTERS	194.00	85,603
	TOTALS		85,603	TOTALS		85,603
500.00	Grand Total: Increases		9,244,952	Grand Total: Decreases		9,244,952

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-7
Part I
Date/Time Prepared:
11/20/2014 10:57 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	869,428	0	0	0	2.00
3.00	Buildings and Fixtures	39,664,393	4,023,019	0	4,023,019	3.00
4.00	Building Improvements	37,608,192	18,632,721	0	18,632,721	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	67,200,403	11,420,735	0	11,420,735	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	145,342,416	34,076,475	0	34,076,475	8.00
9.00	Reconciling Items	17,625,320	4,023,019	0	4,023,019	9.00
10.00	Total (line 8 minus line 9)	127,717,096	30,053,456	0	30,053,456	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0			1.00
2.00	Land Improvements	869,428	0			2.00
3.00	Buildings and Fixtures	43,145,106	0			3.00
4.00	Building Improvements	56,210,735	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	78,000,959	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	178,226,228	0			8.00
9.00	Reconciling Items	21,106,033	0			9.00
10.00	Total (line 8 minus line 9)	157,120,195	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-7
Part II
Date/Time Prepared:
11/20/2014 10:57 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	4,091,330	0	0	171,704	3,740,783	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,726,287	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	12,817,617	0	0	171,704	3,740,783	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	5,970,066	13,973,883				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,997,943	11,724,230				2.00
3.00	Total (sum of lines 1-2)	8,968,009	25,698,113				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-7
Part III
Date/Time Prepared:
11/20/2014 10:57 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	4,709,943	-5,728,348	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	9,458,662	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	14,168,605	-5,728,348	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	-506,628	696,310	2,749,058	5,970,066	7,890,401	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,997,943	12,456,605	2.00
3.00	Total (sum of lines 1-2)	-506,628	696,310	2,749,058	8,968,009	20,347,006	3.00

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on worksheet A To/From which the Amount is to be Adjusted		Line #	wkst. A-7	Ref.
				Cost Center				
				3.00	4.00			
		1.00	2.00				5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-733,238	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)		0			0.00		0 4.00
5.00	Refunds and rebates of expenses (chapter 8)		0			0.00		0 5.00
6.00	Rental of provider space by suppliers (chapter 8)		0			0.00		0 6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0			0.00		0 7.00
8.00	Television and radio service (chapter 21)		0			0.00		0 8.00
9.00	Parking lot (chapter 21)		0			0.00		0 9.00
10.00	Provider-based physician adjustment	A-8-2	-1,253,538					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	-260,871,007					0 12.00
13.00	Laundry and linen service		0			0.00		0 13.00
14.00	Cafeteria-employees and guests	B	-1,380,801	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		0			0.00		0 18.00
19.00	Nursing school (tuition, fees, books, etc.)		0			0.00		0 19.00
20.00	Vending machines	B	-283	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	A	-340,332	CAP REL COSTS-BLDG & FIXT		1.00		9 26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-1,430,028	CAP REL COSTS-MVBLE EQUIP		2.00		9 27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***		19.00		28.00
29.00	Physicians' assistant		0			0.00		0 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***		67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS		30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***		68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0			0.00		0 32.00
33.00	OTHER REVENUE	B	-25	EMPLOYEE BENEFITS		4.00		0 33.00
33.01	OTHER REVENUE	B	-332,739	ADMINISTRATIVE & GENERAL		5.00		0 33.01

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted		
			Cost Center	Line #	Wkst. A-7 Ref.
	1.00	2.00	3.00	4.00	5.00
33.02		0		0.00	0
33.03 OTHER REVENUE	B	743	SOCIAL SERVICE	17.00	0
33.04 OTHER REVENUE	B	-4,552	MEDICAL RECORDS & LIBRARY	16.00	0
33.05		0		0.00	0
34.00 NON-ALLOWABLE EXPENSE	A	-74,083	SOCIAL SERVICE	17.00	0
34.01		0		0.00	0
34.02 NON-ALLOWABLE EXPENSE	A	-2,322	ADULTS & PEDIATRICS	30.00	0
34.03 NON-ALLOWABLE EXPENSE	A	-93	OPERATING ROOM	50.00	0
34.04 NON-ALLOWABLE EXPENSE	A	-46	LABORATORY	60.00	0
34.05 NON-ALLOWABLE EXPENSE	A	-58	RADIOLOGY-DIAGNOSTIC	54.00	0
34.06		0		0.00	0
34.07		0		0.00	0
34.08 NON-ALLOWABLE EXPENSE	A	-228,466	OTHER GENERAL SERVICE (SPECIFY)	18.00	0
34.09 NON-ALLOWABLE EXPENSE	A	-832	DIETARY	10.00	0
34.10		0		0.00	0
34.11 NON-ALLOWABLE EXPENSE	A	-10,648,901	ADMINISTRATIVE & GENERAL	5.00	0
34.12 NON-ALLOWABLE EXPENSE	A	-56	EMPLOYEE BENEFITS	4.00	0
34.13		0		0.00	0
34.14 NON-ALLOWABLE EXPENSE	A	-10,862	HOUSEKEEPING	9.00	0
34.15		0		0.00	0
34.16		0		0.00	0
34.17		0		0.00	0
34.18 NON-ALLOWABLE EXPENSE	A	-95	CLINIC	90.00	0
35.00 NON-ALLOWABLE EXPENSE	A	-20	HOSPITAL NUTRITION	76.01	0
36.00 NON-ALLOWABLE EXPENSE	A	-12	NURSING ADMINISTRATION	13.00	0
37.00 CAFETERIA	A	-2,973,383	CAFETERIA	11.00	0
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-280,285,029			50.00

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

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

Provider CCN: 140100

Period: From 07/01/2013 To 06/30/2014

Worksheet A-8-1

Date/Time Prepared: 11/20/2014 10:57 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	82,072,389
2.00	5.00	ADMINISTRATIVE & GENERAL	RISING TIDE IP REIMBURSEMENT	0	-316,380
3.00	5.00	ADMINISTRATIVE & GENERAL	TRAVEL - AIR CHARTER	97,908	2,760,000
4.00	5.00	ADMINISTRATIVE & GENERAL	GUARANTEE FEES	0	87,041
4.01	113.00	INTEREST EXPENSE	INTEREST EXPENSE - OTHER	0	95,625
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	AMORT EXP - GCF CAP LEASES	4,814,667	4,814,667
4.03	2.00	CAP REL COSTS-MVBLE EQUIP	AMORT EXP - GCF CAP LEASES -	0	1,131,117
4.04	113.00	INTEREST EXPENSE	INTEREST EXPENSE - GCF	0	375,266
4.05	113.00	INTEREST EXPENSE	INTEREST EXPENSE - CAPITAL L	396,877	0
4.06	1.00	CAP REL COSTS-BLDG & FIXT	RENTAL - BLDG	241,718	5,970,066
4.07	5.00	ADMINISTRATIVE & GENERAL	SHARED SERVICES	0	79,060,457
4.08	5.00	ADMINISTRATIVE & GENERAL	CORPORATE ALLOCATION	0	140,367,081
4.09	5.00	ADMINISTRATIVE & GENERAL	INSURANCE - COMMERCIAL	393,376	447,482
4.10	5.00	ADMINISTRATIVE & GENERAL	INSURANCE - STELLAR	1,141,379	4,633,655
4.11	1.00	CAP REL COSTS-BLDG & FIXT	INSURANCE - STELLAR	354,339	524,606
4.12	4.00	EMPLOYEE BENEFITS	INSURANCE - STELLAR	418,499	782,555
4.13	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	958,945	0
4.14	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION	3,293,520	0
4.15	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	49,890,756	0
4.16	5.00	ADMINISTRATIVE & GENERAL	BROKERAGE FEES	0	67,364
5.00	0			62,001,984	322,872,991

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

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

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

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

6.00	A	MIDWESTERN REG	100.00	NIMP	100.00	6.00
7.00	A	MIDWESTERN REG	100.00	CTCA	100.00	7.00
8.00	A	MIDWESTERN REG	100.00	ICIC	100.00	8.00
9.00	A	MIDWESTERN REG	100.00	INTERNATIONAL A	100.00	9.00
10.00	A	MIDWESTERN REG	100.00	SCL	100.00	10.00
10.01	A	MIDWESTERN REG	100.00	EXPEDITION PROP	100.00	10.01
10.02	A	MIDWESTERN REG	100.00	BUCKLEY RD PR	100.00	10.02
10.03	A	MIDWESTERN REG	100.00	LAND TRUST	100.00	10.03
10.04	A	MIDWESTERN REG	100.00	GCF	100.00	10.04
10.05	A	MIDWESTERN REG	100.00	STELLAR INS	100.00	10.05
10.06	A	MIDWESTERN REG	100.00	ICMC	100.00	10.06
10.07			0.00		0.00	10.07
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

	Net Adjustments (col. 4 minus col. 5)*	wkst. A-7 Ref.	
	6.00	7.00	

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

1.00	-82,072,389	0	1.00
2.00	316,380	0	2.00
3.00	-2,662,092	0	3.00
4.00	-87,041	0	4.00
4.01	-95,625	0	4.01
4.02	0	9	4.02
4.03	-1,131,117	9	4.03
4.04	-375,266	0	4.04
4.05	396,877	0	4.05
4.06	-5,728,348	10	4.06
4.07	-79,060,457	0	4.07
4.08	-140,367,081	0	4.08
4.09	-54,106	0	4.09
4.10	-3,492,276	0	4.10
4.11	-170,267	11	4.11
4.12	-364,056	0	4.12
4.13	958,945	9	4.13
4.14	3,293,520	9	4.14
4.15	49,890,756	0	4.15
4.16	-67,364	0	4.16
5.00	-260,871,007		5.00

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

	Related Organization(s) and/or Home Office	
	Type of Business	
	6.00	

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	PROPERTY	6.00
7.00	MANAGEMENT	7.00
8.00	CONSULTING	8.00
9.00	CORPORATE JET	9.00
10.00	SECURITIES FINA	10.00
10.01	RENTS BLDG SHAR	10.01
10.02	PROPERTY COMP	10.02
10.03	PROPERTY COMP	10.03
10.04	FINANCIAL	10.04
10.05	INSURANCE	10.05
10.06	CAPITAL MANAGEM	10.06
10.07		10.07
100.00		100.00

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

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

	1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	10.00	200.00
1.00	91.00	EMERGENCY	1,429,166	1,253,538	175,628	177,200	2,153	1.00			
2.00	0.00		0	0	0	0	0	2.00			
3.00	0.00		0	0	0	0	0	3.00			
4.00	0.00		0	0	0	0	0	4.00			
5.00	0.00		0	0	0	0	0	5.00			
6.00	0.00		0	0	0	0	0	6.00			
7.00	0.00		0	0	0	0	0	7.00			
8.00	0.00		0	0	0	0	0	8.00			
9.00	0.00		0	0	0	0	0	9.00			
10.00	0.00		0	0	0	0	0	10.00			
200.00			1,429,166	1,253,538	175,628		2,153	200.00			
	1.00	2.00	8.00	9.00	12.00	13.00	14.00				
1.00	91.00	EMERGENCY	183,419	9,171	0	0	0	1.00			
2.00	0.00		0	0	0	0	0	2.00			
3.00	0.00		0	0	0	0	0	3.00			
4.00	0.00		0	0	0	0	0	4.00			
5.00	0.00		0	0	0	0	0	5.00			
6.00	0.00		0	0	0	0	0	6.00			
7.00	0.00		0	0	0	0	0	7.00			
8.00	0.00		0	0	0	0	0	8.00			
9.00	0.00		0	0	0	0	0	9.00			
10.00	0.00		0	0	0	0	0	10.00			
200.00			183,419	9,171	0	0	0	200.00			
	1.00	2.00	15.00	16.00	17.00	18.00					
1.00	91.00	EMERGENCY	0	183,419	0	1,253,538		1.00			
2.00	0.00		0	0	0	0		2.00			
3.00	0.00		0	0	0	0		3.00			
4.00	0.00		0	0	0	0		4.00			
5.00	0.00		0	0	0	0		5.00			
6.00	0.00		0	0	0	0		6.00			
7.00	0.00		0	0	0	0		7.00			
8.00	0.00		0	0	0	0		8.00			
9.00	0.00		0	0	0	0		9.00			
10.00	0.00		0	0	0	0		10.00			
200.00			0	183,419	0	1,253,538		200.00			

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet B
Part I
Date/Time Prepared:
11/20/2014 10:57 am

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	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	7,890,401	7,890,401			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	12,456,605		12,456,605		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	19,951,537	194,156	6,271	20,151,964	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	65,833,240	289,138	4,459,872	2,000,898	72,583,148
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	7,860,831	1,929,056	416,861	432,743	10,639,491
8.00 00800	LAUNDRY & LINEN SERVICE	183,300	0	142	0	183,442
9.00 00900	HOUSEKEEPING	2,366,021	123,488	12,677	378,319	2,880,505
10.00 01000	DIETARY	797,537	49,027	36,491	71,495	954,550
11.00 01100	CAFETERIA	938,680	325,122	0	474,007	1,737,809
13.00 01300	NURSING ADMINISTRATION	1,598,847	24,278	1,998	297,134	1,922,257
14.00 01400	CENTRAL SERVICES & SUPPLY	1,063,380	93,357	606,755	124,292	1,887,784
15.00 01500	PHARMACY	3,322,003	127,029	370,742	751,762	4,571,536
16.00 01600	MEDICAL RECORDS & LIBRARY	3,539,224	141,661	2,358	778,361	4,461,604
17.00 01700	SOCIAL SERVICE	1,574,976	49,713	285	262,817	1,887,791
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	8,955,025	333,143	997	1,984,804	11,273,969
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	9,836,332	948,523	151,519	2,162,880	13,099,254
31.00 03100	INTENSIVE CARE UNIT	2,293,332	123,813	131,409	540,850	3,089,404
34.00 03400	SURGICAL INTENSIVE CARE UNIT	2,210,583	0	75,400	518,250	2,804,233
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	6,488,468	491,820	1,660,096	1,135,377	9,775,761
54.00 05400	RADIOLOGY-DIAGNOSTIC	5,141,404	413,023	978,475	933,710	7,466,612
55.00 05500	RADIOLOGY-THERAPEUTIC	5,484,761	467,180	1,329,526	595,908	7,877,375
56.00 05600	RADIOISOTOPE	506,867	14,451	82,353	115,607	719,278
57.00 05700	CT SCAN	847,418	23,917	467,660	153,573	1,492,568
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	690,394	53,687	651,259	116,220	1,511,560
60.00 06000	LABORATORY	9,329,013	261,861	459,234	849,319	10,899,427
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	1,844,796	10,550	44,531	0	1,899,877
64.00 06400	INTRAVENOUS THERAPY	2,649,343	228,261	142	609,387	3,487,133
65.00 06500	RESPIRATORY THERAPY	1,028,807	36,887	37,210	227,831	1,330,735
66.00 06600	PHYSICAL THERAPY	1,629,892	91,008	7,730	298,135	2,026,765
69.00 06900	ELECTROCARDIOLOGY	484,171	9,249	48,535	106,832	648,787
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,816,422	0	0	0	16,816,422
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	79,519,103	0	0	0	79,519,103
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.01 03951	HOSPITAL NUTRITION	1,187,357	26,627	1,534	270,046	1,485,564
76.02 03952	PAIN MANAGEMENT	0	0	0	0	0
76.03 03954	INFUSION CENTER	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	7,110,793	784,499	34,190	1,569,087	9,498,569
91.00 09100	EMERGENCY	1,430,496	120,598	74,242	296,132	1,921,468
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	294,861,359	7,785,122	12,150,494	18,055,776	292,353,781
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	257,967	15,210	0	20,321	293,498
191.00 19100	RESEARCH	538,360	0	1,096	117,231	656,687
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	47,239,787	90,069	305,015	1,958,636	49,593,507
200.00	Cross Foot Adjustments	0	0	0	0	0
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118-201)	342,897,473	7,890,401	12,456,605	20,151,964	342,897,473

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet B
Part I
Date/Time Prepared:
11/20/2014 10:57 am

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	72,583,148					5.00
6.00	00600		0				6.00
7.00	00700	2,856,852	0	13,496,343			7.00
8.00	00800	49,257	0	0	232,699		8.00
9.00	00900	773,456	0	304,239	0	3,958,200	9.00
10.00	01000	256,310	0	120,788	0	36,241	10.00
11.00	01100	466,626	0	801,008	0	240,337	11.00
13.00	01300	516,153	0	59,815	0	17,947	13.00
14.00	01400	506,896	0	230,004	0	69,011	14.00
15.00	01500	1,227,521	0	312,962	0	93,902	15.00
16.00	01600	1,198,003	0	349,011	0	104,718	16.00
17.00	01700	506,898	0	122,479	492	36,749	17.00
18.00	01850	3,027,219	0	820,768	1,007	246,266	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	3,517,333	0	2,336,886	65,838	701,168	30.00
31.00	03100	829,548	0	305,040	9,803	91,525	31.00
34.00	03400	752,976	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,624,929	0	1,211,703	33,109	363,563	50.00
54.00	05400	2,004,890	0	1,017,571	48,304	305,315	54.00
55.00	05500	2,115,185	0	1,150,998	20,276	345,349	55.00
56.00	05600	193,136	0	35,604	0	10,683	56.00
57.00	05700	400,775	0	58,925	0	17,680	57.00
58.00	05800	405,875	0	132,270	0	39,687	58.00
60.00	06000	2,926,649	0	645,150	0	193,573	60.00
63.00	06300	510,144	0	25,991	0	7,798	63.00
64.00	06400	936,344	0	562,370	24,127	168,735	64.00
65.00	06500	357,321	0	90,880	0	27,268	65.00
66.00	06600	544,215	0	224,218	8,310	67,275	66.00
69.00	06900	174,208	0	22,787	1,137	6,837	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	4,515,445	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	21,351,960	0	0	0	0	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	398,895	0	65,601	0	19,683	76.01
76.02	03952	0	0	0	0	0	76.02
76.03	03954	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	2,550,499	0	1,932,779	9,030	579,917	90.00
91.00	09100	515,941	0	297,118	11,266	89,148	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		59,011,459	0	13,236,965	232,699	3,880,375	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	78,808	0	37,474	0	11,244	190.00
191.00	19100	176,330	0	0	0	0	191.00
194.00	07950	13,316,551	0	221,904	0	66,581	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		72,583,148	0	13,496,343	232,699	3,958,200	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	1,367,889					10.00
11.00	01100	0	3,245,780				11.00
13.00	01300	0	54,344	2,570,516			13.00
14.00	01400	0	36,279	0	2,729,974		14.00
15.00	01500	0	122,635	0	0	6,328,556	15.00
16.00	01600	0	170,491	0	0	0	16.00
17.00	01700	0	62,318	0	0	0	17.00
18.00	01850	0	340,682	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,024,425	377,901	952,630	0	0	30.00
31.00	03100	82,235	87,087	219,532	0	0	31.00
34.00	03400	0	124,285	313,304	0	0	34.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	230,162	580,203	0	0	50.00
54.00	05400	0	168,896	0	0	0	54.00
55.00	05500	0	108,957	0	0	0	55.00
56.00	05600	0	14,599	0	0	0	56.00
57.00	05700	0	24,460	0	0	0	57.00
58.00	05800	0	15,899	0	0	0	58.00
60.00	06000	0	173,214	0	0	0	60.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	250,257	112,831	284,428	0	0	64.00
65.00	06500	0	37,951	0	0	0	65.00
66.00	06600	0	53,953	0	0	0	66.00
69.00	06900	0	14,826	37,374	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	2,729,974	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	6,328,556	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	0	58,531	0	0	0	76.01
76.02	03952	0	0	0	0	0	76.02
76.03	03954	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	284,526	56,055	0	0	90.00
91.00	09100	10,972	50,376	126,990	0	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		1,367,889	2,725,203	2,570,516	2,729,974	6,328,556	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	8,223	0	0	0	190.00
191.00	19100	0	24,089	0	0	0	191.00
194.00	07950	0	488,265	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,367,889	3,245,780	2,570,516	2,729,974	6,328,556	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		16.00	17.00	18.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DIETARY						10.00
11.00	01100 CAFETERIA						11.00
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	6,283,827					16.00
17.00	01700 SOCIAL SERVICE	0	2,616,727				17.00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	15,709,911			18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	131,442	54,743	328,629	22,590,249	0	30.00
31.00	03100 INTENSIVE CARE UNIT	25,300	10,537	63,254	4,813,265	0	31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	27,877	11,610	69,697	4,103,982	0	34.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	427,156	177,903	1,067,970	16,492,459	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	272,211	113,371	680,578	12,077,748	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	364,502	151,809	911,322	13,045,773	0	55.00
56.00	05600 RADIOISOTOPE	38,804	16,161	97,018	1,125,283	0	56.00
57.00	05700 CT SCAN	480,127	199,964	1,200,406	3,874,905	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	103,026	42,908	257,583	2,508,808	0	58.00
60.00	06000 LABORATORY	445,838	185,684	1,114,677	16,584,212	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	49,528	20,628	123,830	2,637,796	0	63.00
64.00	06400 INTRAVENOUS THERAPY	172,885	72,004	432,245	6,503,359	0	64.00
65.00	06500 RESPIRATORY THERAPY	13,252	5,519	33,132	1,896,058	0	65.00
66.00	06600 PHYSICAL THERAPY	22,907	9,541	57,273	3,014,457	0	66.00
69.00	06900 ELECTROCARDIOLOGY	44,498	18,533	111,253	1,080,240	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	200,895	83,669	502,274	24,848,679	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	3,408,628	1,419,256	8,521,384	120,548,887	0	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951 HOSPITAL NUTRITION	4,712	1,963	11,781	2,046,730	0	76.01
76.02	03952 PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954 INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	43,399	18,075	108,505	15,081,354	0	90.00
91.00	09100 EMERGENCY	6,840	2,849	17,100	3,050,068	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	6,283,827	2,616,727	15,709,911	277,924,312	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	429,247	0	190.00
191.00	19100 RESEARCH	0	0	0	857,106	0	191.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	63,686,808	0	194.00
200.00	Cross Foot Adjustments				0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	6,283,827	2,616,727	15,709,911	342,897,473	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
6.00	00600 MAINTENANCE & REPAIRS		6.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
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
17.00	01700 SOCIAL SERVICE		17.00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)		18.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	22,590,249	30.00
31.00	03100 INTENSIVE CARE UNIT	4,813,265	31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	4,103,982	34.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	16,492,459	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	12,077,748	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	13,045,773	55.00
56.00	05600 RADIOISOTOPE	1,125,283	56.00
57.00	05700 CT SCAN	3,874,905	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2,508,808	58.00
60.00	06000 LABORATORY	16,584,212	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2,637,796	63.00
64.00	06400 INTRAVENOUS THERAPY	6,503,359	64.00
65.00	06500 RESPIRATORY THERAPY	1,896,058	65.00
66.00	06600 PHYSICAL THERAPY	3,014,457	66.00
69.00	06900 ELECTROCARDIOLOGY	1,080,240	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	24,848,679	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	120,548,887	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	76.00
76.01	03951 HOSPITAL NUTRITION	2,046,730	76.01
76.02	03952 PAIN MANAGEMENT	0	76.02
76.03	03954 INFUSION CENTER	0	76.03
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	15,081,354	90.00
91.00	09100 EMERGENCY	3,050,068	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	277,924,312	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	429,247	190.00
191.00	19100 RESEARCH	857,106	191.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	63,686,808	194.00
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	342,897,473	202.00

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Cost Center Description		Statistics	Statistics	Description	
		Code	Description		
		1.00		2.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE		2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES		4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST		5.00
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET		6.00
7.00	OPERATION OF PLANT	1	SQUARE FEET		7.00
8.00	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY		8.00
9.00	HOUSEKEEPING	1	SQUARE FEET		9.00
10.00	DIETARY	21	MEALS SERVED		10.00
11.00	CAFETERIA	19	ASSIGNED TIME		11.00
13.00	NURSING ADMINISTRATION	13	DIRECT NURS. HRS.		13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.		14.00
15.00	PHARMACY	15	COSTED REQUIS.		15.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS CHARGES		16.00
17.00	SOCIAL SERVICE	C	GROSS CHARGES		17.00
18.00	OTHER GENERAL SERVICE (SPECIFY)	C	GROSS CHARGES		18.00

ALLOCATION OF CAPITAL RELATED COSTS

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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	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	194,156	6,271	200,427	200,427
5.00 00500	ADMINISTRATIVE & GENERAL	0	289,138	4,459,872	4,749,010	19,898
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	0	1,929,056	416,861	2,345,917	4,303
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	142	142	0
9.00 00900	HOUSEKEEPING	0	123,488	12,677	136,165	3,762
10.00 01000	DIETARY	0	49,027	36,491	85,518	711
11.00 01100	CAFETERIA	0	325,122	0	325,122	4,714
13.00 01300	NURSING ADMINISTRATION	0	24,278	1,998	26,276	2,955
14.00 01400	CENTRAL SERVICES & SUPPLY	0	93,357	606,755	700,112	1,236
15.00 01500	PHARMACY	0	127,029	370,742	497,771	7,476
16.00 01600	MEDICAL RECORDS & LIBRARY	0	141,661	2,358	144,019	7,740
17.00 01700	SOCIAL SERVICE	0	49,713	285	49,998	2,614
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	333,143	997	334,140	19,738
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	948,523	151,519	1,100,042	21,533
31.00 03100	INTENSIVE CARE UNIT	0	123,813	131,409	255,222	5,379
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	75,400	75,400	5,154
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	491,820	1,660,096	2,151,916	11,291
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	413,023	978,475	1,391,498	9,285
55.00 05500	RADIOLOGY-THERAPEUTIC	0	467,180	1,329,526	1,796,706	5,926
56.00 05600	RADIOISOTOPE	0	14,451	82,353	96,804	1,150
57.00 05700	CT SCAN	0	23,917	467,660	491,577	1,527
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	53,687	651,259	704,946	1,156
60.00 06000	LABORATORY	0	261,861	459,234	721,095	8,446
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	10,550	44,531	55,081	0
64.00 06400	INTRAVENOUS THERAPY	0	228,261	142	228,403	6,060
65.00 06500	RESPIRATORY THERAPY	0	36,887	37,210	74,097	2,266
66.00 06600	PHYSICAL THERAPY	0	91,008	7,730	98,738	2,965
69.00 06900	ELECTROCARDIOLOGY	0	9,249	48,535	57,784	1,062
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.01 03951	HOSPITAL NUTRITION	0	26,627	1,534	28,161	2,685
76.02 03952	PAIN MANAGEMENT	0	0	0	0	0
76.03 03954	INFUSION CENTER	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	784,499	34,190	818,689	15,604
91.00 09100	EMERGENCY	0	120,598	74,242	194,840	2,945
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	7,785,122	12,150,494	19,935,616	179,581
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,210	0	15,210	202
191.00 19100	RESEARCH	0	0	1,096	1,096	1,166
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	90,069	305,015	395,084	19,478
200.00	Cross Foot Adjustments				0	
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	0	7,890,401	12,456,605	20,347,006	200,427

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	4,768,908					5.00
6.00	00600	0	0				6.00
7.00	00700	187,702	0	2,537,922			7.00
8.00	00800	3,236	0	0	3,378		8.00
9.00	00900	50,818	0	57,211	0	247,956	9.00
10.00	01000	16,840	0	22,714	0	2,270	10.00
11.00	01100	30,658	0	150,626	0	15,056	11.00
13.00	01300	33,912	0	11,248	0	1,124	13.00
14.00	01400	33,304	0	43,251	0	4,323	14.00
15.00	01500	80,651	0	58,851	0	5,882	15.00
16.00	01600	78,712	0	65,630	0	6,560	16.00
17.00	01700	33,304	0	23,032	7	2,302	17.00
18.00	01850	198,895	0	154,341	15	15,427	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	231,097	0	439,437	955	43,925	30.00
31.00	03100	54,503	0	57,361	142	5,733	31.00
34.00	03400	49,472	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	172,464	0	227,855	481	22,775	50.00
54.00	05400	131,726	0	191,349	701	19,126	54.00
55.00	05500	138,973	0	216,440	294	21,634	55.00
56.00	05600	12,690	0	6,695	0	669	56.00
57.00	05700	26,332	0	11,081	0	1,108	57.00
58.00	05800	26,667	0	24,873	0	2,486	58.00
60.00	06000	192,288	0	121,317	0	12,126	60.00
63.00	06300	33,518	0	4,888	0	489	63.00
64.00	06400	61,520	0	105,751	350	10,570	64.00
65.00	06500	23,477	0	17,090	0	1,708	65.00
66.00	06600	35,756	0	42,163	121	4,214	66.00
69.00	06900	11,446	0	4,285	17	428	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	296,675	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	1,402,899	0	0	0	0	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	26,208	0	12,336	0	1,233	76.01
76.02	03952	0	0	0	0	0	76.02
76.03	03954	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	167,574	0	363,450	131	36,328	90.00
91.00	09100	33,899	0	55,872	164	5,585	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		3,877,216	0	2,489,147	3,378	243,081	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	5,178	0	7,047	0	704	190.00
191.00	19100	11,585	0	0	0	0	191.00
194.00	07950	874,929	0	41,728	0	4,171	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		4,768,908	0	2,537,922	3,378	247,956	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet B
Part II
Date/Time Prepared:
11/20/2014 10:57 am

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	128,053					10.00
11.00	01100	0	526,176				11.00
13.00	01300	0	8,810	84,325			13.00
14.00	01400	0	5,881	0	788,107		14.00
15.00	01500	0	19,880	0	0	670,511	15.00
16.00	01600	0	27,638	0	0	0	16.00
17.00	01700	0	10,102	0	0	0	17.00
18.00	01850	0	55,228	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	95,901	61,262	31,250	0	0	30.00
31.00	03100	7,698	14,118	7,202	0	0	31.00
34.00	03400	0	20,148	10,278	0	0	34.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	37,312	19,033	0	0	50.00
54.00	05400	0	27,380	0	0	0	54.00
55.00	05500	0	17,663	0	0	0	55.00
56.00	05600	0	2,367	0	0	0	56.00
57.00	05700	0	3,965	0	0	0	57.00
58.00	05800	0	2,577	0	0	0	58.00
60.00	06000	0	28,080	0	0	0	60.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	23,427	18,291	9,331	0	0	64.00
65.00	06500	0	6,152	0	0	0	65.00
66.00	06600	0	8,746	0	0	0	66.00
69.00	06900	0	2,403	1,226	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	788,107	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	670,511	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	0	9,488	0	0	0	76.01
76.02	03952	0	0	0	0	0	76.02
76.03	03954	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	46,125	1,839	0	0	90.00
91.00	09100	1,027	8,166	4,166	0	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		128,053	441,782	84,325	788,107	670,511	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	1,333	0	0	0	190.00
191.00	19100	0	3,905	0	0	0	191.00
194.00	07950	0	79,156	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		128,053	526,176	84,325	788,107	670,511	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet B
Part II
Date/Time Prepared:
11/20/2014 10:57 am

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		16.00	17.00	18.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500						15.00
16.00	01600	330,299					16.00
17.00	01700	0	121,359				17.00
18.00	01850	0	0	777,784			18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	6,907	2,545	16,261	2,051,115	0	30.00
31.00	03100	1,329	490	3,130	412,307	0	31.00
34.00	03400	1,465	540	3,449	165,906	0	34.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	22,445	8,269	52,843	2,726,684	0	50.00
54.00	05400	14,303	5,270	33,675	1,824,313	0	54.00
55.00	05500	19,152	7,056	45,092	2,268,936	0	55.00
56.00	05600	2,039	751	4,800	127,965	0	56.00
57.00	05700	25,228	9,294	59,396	629,508	0	57.00
58.00	05800	5,413	1,994	12,745	782,857	0	58.00
60.00	06000	23,426	8,631	55,154	1,170,563	0	60.00
63.00	06300	2,602	959	6,127	103,664	0	63.00
64.00	06400	9,084	3,347	21,388	497,522	0	64.00
65.00	06500	696	257	1,639	127,382	0	65.00
66.00	06600	1,204	443	2,834	197,184	0	66.00
69.00	06900	2,338	861	5,505	87,355	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	10,556	3,889	24,853	1,124,080	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	179,225	65,700	422,095	2,740,430	0	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	248	91	583	81,033	0	76.01
76.02	03952	0	0	0	0	0	76.02
76.03	03954	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	2,280	840	5,369	1,458,229	0	90.00
91.00	09100	359	132	846	308,001	0	91.00
92.00	09200					0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		330,299	121,359	777,784	18,885,034	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	29,674	0	190.00
191.00	19100	0	0	0	17,752	0	191.00
194.00	07950	0	0	0	1,414,546	0	194.00
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		330,299	121,359	777,784	20,347,006	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet B
Part II
Date/Time Prepared:
11/20/2014 10:57 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
6.00	00600 MAINTENANCE & REPAIRS		6.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
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
17.00	01700 SOCIAL SERVICE		17.00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)		18.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	2,051,115	30.00
31.00	03100 INTENSIVE CARE UNIT	412,307	31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	165,906	34.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	2,726,684	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,824,313	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	2,268,936	55.00
56.00	05600 RADIOISOTOPE	127,965	56.00
57.00	05700 CT SCAN	629,508	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	782,857	58.00
60.00	06000 LABORATORY	1,170,563	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	103,664	63.00
64.00	06400 INTRAVENOUS THERAPY	497,522	64.00
65.00	06500 RESPIRATORY THERAPY	127,382	65.00
66.00	06600 PHYSICAL THERAPY	197,184	66.00
69.00	06900 ELECTROCARDIOLOGY	87,355	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,124,080	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,740,430	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	76.00
76.01	03951 HOSPITAL NUTRITION	81,033	76.01
76.02	03952 PAIN MANAGEMENT	0	76.02
76.03	03954 INFUSION CENTER	0	76.03
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	1,458,229	90.00
91.00	09100 EMERGENCY	308,001	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	18,885,034	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	29,674	190.00
191.00	19100 RESEARCH	17,752	191.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	1,414,546	194.00
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	20,347,006	202.00

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	4.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT	218,397					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		12,456,602				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	5,374	6,271	76,169,469			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	8,003	4,459,869	7,562,917	-72,583,148	270,314,325	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	53,394	416,861	1,635,666	0	10,639,491	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	142	0	0	183,442	8.00
9.00 00900	HOUSEKEEPING	3,418	12,677	1,429,955	0	2,880,505	9.00
10.00 01000	DIETARY	1,357	36,491	270,233	0	954,550	10.00
11.00 01100	CAFETERIA	8,999	0	1,791,633	0	1,737,809	11.00
13.00 01300	NURSING ADMINISTRATION	672	1,998	1,123,095	0	1,922,257	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	2,584	606,755	469,795	0	1,887,784	14.00
15.00 01500	PHARMACY	3,516	370,742	2,841,479	0	4,571,536	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	3,921	2,358	2,942,020	0	4,461,604	16.00
17.00 01700	SOCIAL SERVICE	1,376	285	993,385	0	1,887,791	17.00
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	9,221	997	7,502,085	0	11,273,969	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	26,254	151,519	8,175,037	0	13,099,254	30.00
31.00 03100	INTENSIVE CARE UNIT	3,427	131,409	2,044,282	0	3,089,404	31.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	75,400	1,958,861	0	2,804,233	34.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	13,613	1,660,096	4,291,453	0	9,775,761	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	11,432	978,475	3,529,201	0	7,466,612	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	12,931	1,329,526	2,252,390	0	7,877,375	55.00
56.00 05600	RADIOISOTOPE	400	82,353	436,966	0	719,278	56.00
57.00 05700	CT SCAN	662	467,660	580,469	0	1,492,568	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	1,486	651,259	439,285	0	1,511,560	58.00
60.00 06000	LABORATORY	7,248	459,234	3,210,222	0	10,899,427	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	292	44,531	0	0	1,899,877	63.00
64.00 06400	INTRAVENOUS THERAPY	6,318	142	2,303,338	0	3,487,133	64.00
65.00 06500	RESPIRATORY THERAPY	1,021	37,210	861,146	0	1,330,735	65.00
66.00 06600	PHYSICAL THERAPY	2,519	7,730	1,126,879	0	2,026,765	66.00
69.00 06900	ELECTROCARDIOLOGY	256	48,535	403,798	0	648,787	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	16,816,422	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	79,519,103	73.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01 03951	HOSPITAL NUTRITION	737	1,534	1,020,709	0	1,485,564	76.01
76.02 03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03 03954	INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	21,714	34,190	5,930,773	0	9,498,569	90.00
91.00 09100	EMERGENCY	3,338	74,242	1,119,309	0	1,921,468	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	215,483	12,150,491	68,246,381	-72,583,148	219,770,633	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	421	0	76,809	0	293,498	190.00
191.00 19100	RESEARCH	0	1,096	443,105	0	656,687	191.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	2,493	305,015	7,403,174	0	49,593,507	194.00
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)	7,890,401	12,456,605	20,151,964		72,583,148	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	36.128706	1.000000	0.264567		0.268514	203.00
204.00	Cost to be allocated (per wkst. B, Part II)			200,427		4,768,908	204.00
205.00	Unit cost multiplier (wkst. B, Part II)			0.002631		0.017642	205.00

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	205,020					6.00
7.00	00700	53,394	151,626				7.00
8.00	00800	0	0	574,623			8.00
9.00	00900	3,418	3,418	0	148,208		9.00
10.00	01000	1,357	1,357	0	1,357	38,524	10.00
11.00	01100	8,999	8,999	0	8,999	0	11.00
13.00	01300	672	672	0	672	0	13.00
14.00	01400	2,584	2,584	0	2,584	0	14.00
15.00	01500	3,516	3,516	0	3,516	0	15.00
16.00	01600	3,921	3,921	0	3,921	0	16.00
17.00	01700	1,376	1,376	1,215	1,376	0	17.00
18.00	01850	9,221	9,221	2,486	9,221	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	26,254	26,254	162,579	26,254	28,851	30.00
31.00	03100	3,427	3,427	24,207	3,427	2,316	31.00
34.00	03400	0	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	13,613	13,613	81,759	13,613	0	50.00
54.00	05400	11,432	11,432	119,281	11,432	0	54.00
55.00	05500	12,931	12,931	50,070	12,931	0	55.00
56.00	05600	400	400	0	400	0	56.00
57.00	05700	662	662	0	662	0	57.00
58.00	05800	1,486	1,486	0	1,486	0	58.00
60.00	06000	7,248	7,248	0	7,248	0	60.00
63.00	06300	292	292	0	292	0	63.00
64.00	06400	6,318	6,318	59,580	6,318	7,048	64.00
65.00	06500	1,021	1,021	0	1,021	0	65.00
66.00	06600	2,519	2,519	20,521	2,519	0	66.00
69.00	06900	256	256	2,807	256	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	737	737	0	737	0	76.01
76.02	03952	0	0	0	0	0	76.02
76.03	03954	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	21,714	21,714	22,299	21,714	0	90.00
91.00	09100	3,338	3,338	27,819	3,338	309	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		202,106	148,712	574,623	145,294	38,524	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	421	421	0	421	0	190.00
191.00	19100	0	0	0	0	0	191.00
194.00	07950	2,493	2,493	0	2,493	0	194.00
200.00							200.00
201.00							201.00
202.00		0	13,496,343	232,699	3,958,200	1,367,889	202.00
203.00		0.000000	89.010744	0.404959	26.707060	35.507450	203.00
204.00		0	2,537,922	3,378	247,956	128,053	204.00
205.00		0.000000	16.738040	0.005879	1.673027	3.323980	205.00

Cost Center Description		CAFETERIA (ASSIGNED TIME)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		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
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	2,002,517					11.00
13.00	01300	33,528	629,117				13.00
14.00	01400	22,383	0	1,000			14.00
15.00	01500	75,661	0	0	1,000		15.00
16.00	01600	105,186	0	0	0	1,158,483,178	16.00
17.00	01700	38,448	0	0	0	0	17.00
18.00	01850	210,187	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	233,150	233,150	0	0	24,233,379	30.00
31.00	03100	53,729	53,729	0	0	4,664,426	31.00
34.00	03400	76,679	76,679	0	0	5,139,525	34.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	142,001	142,001	0	0	78,753,007	50.00
54.00	05400	104,202	0	0	0	50,186,422	54.00
55.00	05500	67,222	0	0	0	67,201,710	55.00
56.00	05600	9,007	0	0	0	7,154,204	56.00
57.00	05700	15,091	0	0	0	88,518,958	57.00
58.00	05800	9,809	0	0	0	18,994,389	58.00
60.00	06000	106,866	0	0	0	82,197,272	60.00
63.00	06300	0	0	0	0	9,131,310	63.00
64.00	06400	69,612	69,612	0	0	31,874,118	64.00
65.00	06500	23,414	0	0	0	2,443,168	65.00
66.00	06600	33,287	0	0	0	4,223,336	66.00
69.00	06900	9,147	9,147	0	0	8,203,892	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	1,000	0	37,038,119	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	1,000	628,394,983	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	36,111	0	0	0	868,748	76.01
76.02	03952	0	0	0	0	0	76.02
76.03	03954	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	175,541	13,719	0	0	8,001,242	90.00
91.00	09100	31,080	31,080	0	0	1,260,970	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		1,681,341	629,117	1,000	1,000	1,158,483,178	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	5,073	0	0	0	0	190.00
191.00	19100	14,862	0	0	0	0	191.00
194.00	07950	301,241	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		3,245,780	2,570,516	2,729,974	6,328,556	6,283,827	202.00
203.00		1.620850	4.085911	2,729.974000	6,328.556000	0.005424	203.00
204.00		526,176	84,325	788,107	670,511	330,299	204.00
205.00		0.262757	0.134037	788.107000	670.511000	0.000285	205.00

Cost Center Description		SOCIAL SERVICE (GROSS CHARGES)	OTHER GENERAL SERVICE (SPECIFY) (GROSS CHARGES)	
			17.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
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
17.00	01700	SOCIAL SERVICE	1,158,483,178	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0 1,158,483,178	18.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	24,233,379	30.00
31.00	03100	INTENSIVE CARE UNIT	4,664,426	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	5,139,525	34.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	78,753,007	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	50,186,422	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	67,201,710	55.00
56.00	05600	RADIOISOTOPE	7,154,204	56.00
57.00	05700	CT SCAN	88,518,958	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	18,994,389	58.00
60.00	06000	LABORATORY	82,197,272	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	9,131,310	63.00
64.00	06400	INTRAVENOUS THERAPY	31,874,118	64.00
65.00	06500	RESPIRATORY THERAPY	2,443,168	65.00
66.00	06600	PHYSICAL THERAPY	4,223,336	66.00
69.00	06900	ELECTROCARDIOLOGY	8,203,892	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	37,038,119	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	628,394,983	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	76.00
76.01	03951	HOSPITAL NUTRITION	868,748	76.01
76.02	03952	PAIN MANAGEMENT	0	76.02
76.03	03954	INFUSION CENTER	0	76.03
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	8,001,242	90.00
91.00	09100	EMERGENCY	1,260,970	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,158,483,178	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
191.00	19100	RESEARCH	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	194.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per wkst. B, Part I)	2,616,727	202.00
203.00		Unit cost multiplier (wkst. B, Part I)	0.002259	203.00
204.00		Cost to be allocated (per wkst. B, Part II)	121,359	204.00
205.00		Unit cost multiplier (wkst. B, Part II)	0.000105	205.00

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII		Hospital		PPS	
				Total Costs	Costs		Total Costs		
					RCE Disallowance				
		1.00	2.00	3.00	4.00	5.00			
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	22,590,249		22,590,249		0	22,590,249	30.00
31.00	03100	INTENSIVE CARE UNIT	4,813,265		4,813,265		0	4,813,265	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	4,103,982		4,103,982		0	4,103,982	34.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	16,492,459		16,492,459		0	16,492,459	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,077,748		12,077,748		0	12,077,748	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	13,045,773		13,045,773		0	13,045,773	55.00
56.00	05600	RADIOISOTOPE	1,125,283		1,125,283		0	1,125,283	56.00
57.00	05700	CT SCAN	3,874,905		3,874,905		0	3,874,905	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,508,808		2,508,808		0	2,508,808	58.00
60.00	06000	LABORATORY	16,584,212		16,584,212		0	16,584,212	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,637,796		2,637,796		0	2,637,796	63.00
64.00	06400	INTRAVENOUS THERAPY	6,503,359		6,503,359		0	6,503,359	64.00
65.00	06500	RESPIRATORY THERAPY	1,896,058	0	1,896,058		0	1,896,058	65.00
66.00	06600	PHYSICAL THERAPY	3,014,457	0	3,014,457		0	3,014,457	66.00
69.00	06900	ELECTROCARDIOLOGY	1,080,240		1,080,240		0	1,080,240	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0		0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,848,679		24,848,679		0	24,848,679	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0		0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	120,548,887		120,548,887		0	120,548,887	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0		0	0	76.00
76.01	03951	HOSPITAL NUTRITION	2,046,730		2,046,730		0	2,046,730	76.01
76.02	03952	PAIN MANAGEMENT	0		0		0	0	76.02
76.03	03954	INFUSION CENTER	0		0		0	0	76.03
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	15,081,354		15,081,354		0	15,081,354	90.00
91.00	09100	EMERGENCY	3,050,068		3,050,068		0	3,050,068	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,370,906		2,370,906		0	2,370,906	92.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	280,295,218	0	280,295,218		0	280,295,218	200.00
201.00		Less Observation Beds	2,370,906		2,370,906		0	2,370,906	201.00
202.00		Total (see instructions)	277,924,312	0	277,924,312		0	277,924,312	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet C
Part I
Date/Time Prepared:
11/20/2014 10:57 am

		Title XVIII			Hospital	PPS
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
9.00	10.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,086,454		22,086,454	30.00
31.00	03100	INTENSIVE CARE UNIT	4,664,426		4,664,426	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	5,139,525		5,139,525	34.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	42,587,326	36,165,681	78,753,007	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,138,868	43,047,554	50,186,422	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,042,007	64,159,703	67,201,710	55.00
56.00	05600	RADIOISOTOPE	261,001	6,893,203	7,154,204	56.00
57.00	05700	CT SCAN	5,567,951	82,951,007	88,518,958	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,954,065	17,040,324	18,994,389	58.00
60.00	06000	LABORATORY	16,014,197	66,183,075	82,197,272	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,704,453	3,426,857	9,131,310	63.00
64.00	06400	INTRAVENOUS THERAPY	71,697	31,802,421	31,874,118	64.00
65.00	06500	RESPIRATORY THERAPY	1,576,020	867,148	2,443,168	65.00
66.00	06600	PHYSICAL THERAPY	2,264,350	1,958,986	4,223,336	66.00
69.00	06900	ELECTROCARDIOLOGY	1,553,052	6,650,840	8,203,892	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,889,918	16,148,201	37,038,119	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	80,757,931	547,637,052	628,394,983	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	25,779	842,969	868,748	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	704,204	7,297,038	8,001,242	90.00
91.00	09100	EMERGENCY	114,720	1,146,250	1,260,970	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	823,114	1,323,811	2,146,925	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	222,941,058	935,542,120	1,158,483,178	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	222,941,058	935,542,120	1,158,483,178	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet C
Part I
Date/Time Prepared:
11/20/2014 10:57 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT				34.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.209420			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.240658			54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.194129			55.00
56.00	05600 RADIOISOTOPE	0.157290			56.00
57.00	05700 CT SCAN	0.043775			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.132082			58.00
60.00	06000 LABORATORY	0.201761			60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.288874			63.00
64.00	06400 INTRAVENOUS THERAPY	0.204033			64.00
65.00	06500 RESPIRATORY THERAPY	0.776065			65.00
66.00	06600 PHYSICAL THERAPY	0.713762			66.00
69.00	06900 ELECTROCARDIOLOGY	0.131674			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.670895			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.191836			73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000			76.00
76.01	03951 HOSPITAL NUTRITION	2.355954			76.01
76.02	03952 PAIN MANAGEMENT	0.000000			76.02
76.03	03954 INFUSION CENTER	0.000000			76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	1.884877			90.00
91.00	09100 EMERGENCY	2.418827			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.104326			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital		Cost
				Total Costs	RCE Disallowance	Total Costs		
								3.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000 ADULTS & PEDIATRICS	22,590,249		22,590,249	0	22,590,249		30.00
31.00	03100 INTENSIVE CARE UNIT	4,813,265		4,813,265	0	4,813,265		31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	4,103,982		4,103,982	0	4,103,982		34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	16,492,459		16,492,459	0	16,492,459		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	12,077,748		12,077,748	0	12,077,748		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	13,045,773		13,045,773	0	13,045,773		55.00
56.00	05600 RADIOISOTOPE	1,125,283		1,125,283	0	1,125,283		56.00
57.00	05700 CT SCAN	3,874,905		3,874,905	0	3,874,905		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2,508,808		2,508,808	0	2,508,808		58.00
60.00	06000 LABORATORY	16,584,212		16,584,212	0	16,584,212		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2,637,796		2,637,796	0	2,637,796		63.00
64.00	06400 INTRAVENOUS THERAPY	6,503,359		6,503,359	0	6,503,359		64.00
65.00	06500 RESPIRATORY THERAPY	1,896,058	0	1,896,058	0	1,896,058		65.00
66.00	06600 PHYSICAL THERAPY	3,014,457	0	3,014,457	0	3,014,457		66.00
69.00	06900 ELECTROCARDIOLOGY	1,080,240		1,080,240	0	1,080,240		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	24,848,679		24,848,679	0	24,848,679		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	120,548,887		120,548,887	0	120,548,887		73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0		76.00
76.01	03951 HOSPITAL NUTRITION	2,046,730		2,046,730	0	2,046,730		76.01
76.02	03952 PAIN MANAGEMENT	0		0	0	0		76.02
76.03	03954 INFUSION CENTER	0		0	0	0		76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000 CLINIC	15,081,354		15,081,354	0	15,081,354		90.00
91.00	09100 EMERGENCY	3,050,068		3,050,068	0	3,050,068		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,370,906		2,370,906	0	2,370,906		92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300 INTEREST EXPENSE							113.00
200.00	Subtotal (see instructions)	280,295,218	0	280,295,218	0	280,295,218		200.00
201.00	Less Observation Beds	2,370,906		2,370,906		2,370,906		201.00
202.00	Total (see instructions)	277,924,312	0	277,924,312	0	277,924,312		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet C
Part I
Date/Time Prepared:
11/20/2014 10:57 am

Cost Center Description		Title XIX			Hospital	Cost		
		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	22,086,454		22,086,454			30.00
31.00	03100	INTENSIVE CARE UNIT	4,664,426		4,664,426			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	5,139,525		5,139,525			34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	42,587,326	36,165,681	78,753,007	0.209420	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,138,868	43,047,554	50,186,422	0.240658	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,042,007	64,159,703	67,201,710	0.194129	0.000000	55.00
56.00	05600	RADIOISOTOPE	261,001	6,893,203	7,154,204	0.157290	0.000000	56.00
57.00	05700	CT SCAN	5,567,951	82,951,007	88,518,958	0.043775	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,954,065	17,040,324	18,994,389	0.132082	0.000000	58.00
60.00	06000	LABORATORY	16,014,197	66,183,075	82,197,272	0.201761	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,704,453	3,426,857	9,131,310	0.288874	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	71,697	31,802,421	31,874,118	0.204033	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,576,020	867,148	2,443,168	0.776065	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,264,350	1,958,986	4,223,336	0.713762	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	1,553,052	6,650,840	8,203,892	0.131674	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,889,918	16,148,201	37,038,119	0.670895	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	80,757,931	547,637,052	628,394,983	0.191836	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
76.01	03951	HOSPITAL NUTRITION	25,779	842,969	868,748	2.355954	0.000000	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	76.02
76.03	03954	INFUSION CENTER	0	0	0	0.000000	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	704,204	7,297,038	8,001,242	1.884877	0.000000	90.00
91.00	09100	EMERGENCY	114,720	1,146,250	1,260,970	2.418827	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	823,114	1,323,811	2,146,925	1.104326	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	222,941,058	935,542,120	1,158,483,178			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	222,941,058	935,542,120	1,158,483,178			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet C
Part I
Date/Time Prepared:
11/20/2014 10:57 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT				34.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	05600 RADIOISOTOPE	0.000000			56.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000 LABORATORY	0.000000			60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000			76.00
76.01	03951 HOSPITAL NUTRITION	0.000000			76.01
76.02	03952 PAIN MANAGEMENT	0.000000			76.02
76.03	03954 INFUSION CENTER	0.000000			76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet D
Part I
Date/Time Prepared:
11/20/2014 10:57 am

Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	2,051,115	0	2,051,115	9,833	208.60	30.00	
31.00	INTENSIVE CARE UNIT	412,307		412,307	1,543	267.21	31.00	
34.00	SURGICAL INTENSIVE CARE UNIT	165,906		165,906	2,000	82.95	34.00	
200.00	Total (lines 30-199)	2,629,328		2,629,328	13,376		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	834	173,972					30.00
31.00	INTENSIVE CARE UNIT	127	33,936					31.00
34.00	SURGICAL INTENSIVE CARE UNIT	87	7,217					34.00
200.00	Total (lines 30-199)	1,048	215,125					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet D
Part II
Date/Time Prepared:
11/20/2014 10:57 am

Cost Center Description			Title XVIII			Hospital	PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,726,684	78,753,007	0.034623	2,467,828	85,444	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,824,313	50,186,422	0.036351	712,614	25,904	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,268,936	67,201,710	0.033763	263,090	8,883	55.00
56.00	05600	RADIOISOTOPE	127,965	7,154,204	0.017887	23,159	414	56.00
57.00	05700	CT SCAN	629,508	88,518,958	0.007112	446,941	3,179	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	782,857	18,994,389	0.041215	110,184	4,541	58.00
60.00	06000	LABORATORY	1,170,563	82,197,272	0.014241	1,450,796	20,661	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	103,664	9,131,310	0.011353	591,004	6,710	63.00
64.00	06400	INTRAVENOUS THERAPY	497,522	31,874,118	0.015609	11,828	185	64.00
65.00	06500	RESPIRATORY THERAPY	127,382	2,443,168	0.052138	173,942	9,069	65.00
66.00	06600	PHYSICAL THERAPY	197,184	4,223,336	0.046689	166,040	7,752	66.00
69.00	06900	ELECTROCARDIOLOGY	87,355	8,203,892	0.010648	180,275	1,920	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,124,080	37,038,119	0.030349	1,464,391	44,443	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	2,740,430	628,394,983	0.004361	7,168,011	31,260	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	81,033	868,748	0.093276	1,870	174	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0.000000	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0.000000	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,458,229	8,001,242	0.182250	105,601	19,246	90.00
91.00	09100	EMERGENCY	308,001	1,260,970	0.244257	11,155	2,725	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	215,269	2,146,925	0.100269	0	0	92.00
200.00		Total (lines 50-199)	16,470,975	1,126,592,773		15,348,729	272,510	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140100		Period: From 07/01/2013 To 06/30/2014		Worksheet D Part III Date/Time Prepared: 11/20/2014 10:57 am		
Cost Center Description		Title XVIII			Hospital		PPS	
		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00	
200.00		Total (lines 30-199)	0	0	0	0	200.00	
Cost Center Description		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School		
		6.00	7.00	8.00	9.00	11.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,833	0.00	834	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	1,543	0.00	127	0	31.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	2,000	0.00	87	0	34.00	
200.00		Total (lines 30-199)	13,376		1,048	0	200.00	
Cost Center Description		PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost					
		12.00	13.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0				30.00
31.00	03100	INTENSIVE CARE UNIT	0	0				31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0				34.00
200.00		Total (lines 30-199)	0	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet D
Part IV
Date/Time Prepared:
11/20/2014 10:57 am

Cost Center Description	Title XVIII			Hospital	PPS	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01 03951 HOSPITAL NUTRITION	0	0	0	0	0	76.01
76.02 03952 PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03 03954 INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140100

Period: From 07/01/2013 To 06/30/2014

Worksheet D Part IV Date/Time Prepared: 11/20/2014 10:57 am

Cost Center Description		Title XVIII			Hospital		PPS
		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	78,753,007	0.000000	0.000000	2,467,828	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	50,186,422	0.000000	0.000000	712,614	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	67,201,710	0.000000	0.000000	263,090	55.00
56.00	05600 RADIOISOTOPE	0	7,154,204	0.000000	0.000000	23,159	56.00
57.00	05700 CT SCAN	0	88,518,958	0.000000	0.000000	446,941	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	18,994,389	0.000000	0.000000	110,184	58.00
60.00	06000 LABORATORY	0	82,197,272	0.000000	0.000000	1,450,796	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	9,131,310	0.000000	0.000000	591,004	63.00
64.00	06400 INTRAVENOUS THERAPY	0	31,874,118	0.000000	0.000000	11,828	64.00
65.00	06500 RESPIRATORY THERAPY	0	2,443,168	0.000000	0.000000	173,942	65.00
66.00	06600 PHYSICAL THERAPY	0	4,223,336	0.000000	0.000000	166,040	66.00
69.00	06900 ELECTROCARDIOLOGY	0	8,203,892	0.000000	0.000000	180,275	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	37,038,119	0.000000	0.000000	1,464,391	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	628,394,983	0.000000	0.000000	7,168,011	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.01	03951 HOSPITAL NUTRITION	0	868,748	0.000000	0.000000	1,870	76.01
76.02	03952 PAIN MANAGEMENT	0	0	0.000000	0.000000	0	76.02
76.03	03954 INFUSION CENTER	0	0	0.000000	0.000000	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	8,001,242	0.000000	0.000000	105,601	90.00
91.00	09100 EMERGENCY	0	1,260,970	0.000000	0.000000	11,155	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2,146,925	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	1,126,592,773			15,348,729	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet D
Part IV
Date/Time Prepared:
11/20/2014 10:57 am

Cost Center Description		Title XVIII			Hospital	PPS	
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	2,425,196	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	3,486,311	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	4,579,741	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0	706,562	0	0	0	56.00
57.00	05700 CT SCAN	0	8,657,665	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1,093,963	0	0	0	58.00
60.00	06000 LABORATORY	0	2,377,129	0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	249,417	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	2,138,188	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	55,402	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	474,752	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	1,046,423	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	37,597,211	0	0	0	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951 HOSPITAL NUTRITION	0	0	0	0	0	76.01
76.02	03952 PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954 INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	600,178	0	0	0	90.00
91.00	09100 EMERGENCY	0	93,026	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	65,581,164	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet D
Part IV
Date/Time Prepared:
11/20/2014 10:57 am

Cost Center Description		Title XVIII		Hospital	PPS
		PSA Adj. Allied Health 23.00	PSA Adj. All Other Medical Education Cost 24.00		
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600 RADIOISOTOPE	0	0		56.00
57.00	05700 CT SCAN	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000 LABORATORY	0	0		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400 INTRAVENOUS THERAPY	0	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0		66.00
69.00	06900 ELECTROCARDIOLOGY	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.01	03951 HOSPITAL NUTRITION	0	0		76.01
76.02	03952 PAIN MANAGEMENT	0	0		76.02
76.03	03954 INFUSION CENTER	0	0		76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0		90.00
91.00	09100 EMERGENCY	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00	Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet D
Part V
Date/Time Prepared:
11/20/2014 10:57 am

		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	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.209420	2,425,196	0	0	507,885	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.240658	3,486,311	0	0	839,009	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.194129	4,579,741	0	0	889,061	55.00
56.00	05600 RADIOISOTOPE	0.157290	706,562	0	0	111,135	56.00
57.00	05700 CT SCAN	0.043775	8,657,665	0	0	378,989	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.132082	1,093,963	0	0	144,493	58.00
60.00	06000 LABORATORY	0.201761	2,377,129	163,190	0	479,612	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.288874	249,417	0	0	72,050	63.00
64.00	06400 INTRAVENOUS THERAPY	0.204033	2,138,188	0	0	436,261	64.00
65.00	06500 RESPIRATORY THERAPY	0.776065	55,402	0	0	42,996	65.00
66.00	06600 PHYSICAL THERAPY	0.713762	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.131674	474,752	0	0	62,512	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.670895	1,046,423	0	0	702,040	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	0.191836	37,597,211	1,391	163,675	7,212,499	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.01	03951 HOSPITAL NUTRITION	2.355954	0	0	0	0	76.01
76.02	03952 PAIN MANAGEMENT	0.000000	0	0	0	0	76.02
76.03	03954 INFUSION CENTER	0.000000	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	1.884877	600,178	0	272	1,131,262	90.00
91.00	09100 EMERGENCY	2.418827	93,026	351	0	225,014	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.104326	0	0	0	0	92.00
200.00	Subtotal (see instructions)		65,581,164	164,932	163,947	13,234,818	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		65,581,164	164,932	163,947	13,234,818	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet D
Part V
Date/Time Prepared:
11/20/2014 10:57 am

Cost Center Description		Costs		Hospital	PPS
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600 RADIOISOTOPE	0	0		56.00
57.00	05700 CT SCAN	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000 LABORATORY	32,925	0		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400 INTRAVENOUS THERAPY	0	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0		66.00
69.00	06900 ELECTROCARDIOLOGY	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	267	31,399		73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.01	03951 HOSPITAL NUTRITION	0	0		76.01
76.02	03952 PAIN MANAGEMENT	0	0		76.02
76.03	03954 INFUSION CENTER	0	0		76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	513		90.00
91.00	09100 EMERGENCY	849	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00	Subtotal (see instructions)	34,041	31,912		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00	Net charges (line 200 +/- line 201)	34,041	31,912		202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet D 1

Date/Time Prepared:
11/20/2014 10:57 am

Cost Center Description		Title XVIII	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			9,833 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			9,833 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)			8,801 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)			834 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			22,590,249 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)			22,590,249 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			22,590,249 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			2,297.39 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,916,023 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)			1,916,023 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet D-1

Date/Time Prepared:
11/20/2014 10:57 am

Cost Center Description	Title XVIII			Hospital	PPS	42.00
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	4,813,265	1,543	3,119.42	127	396,166	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT	4,103,982	2,000	2,051.99	87	178,523	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)					4,108,206	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,598,918	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)					215,125	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					272,510	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					487,635	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					6,111,283	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)					1,032	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,297.39	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					2,370,906	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet D-1
Date/Time Prepared:
11/20/2014 10:57 am

Cost Center Description	Cost	Title XVIII		Hospital		Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00 Capital-related cost	2,051,115	22,590,249	0.090796	2,370,906	215,269	90.00	90.00
91.00 Nursing School cost	0	22,590,249	0.000000	2,370,906	0	91.00	91.00
92.00 Allied health cost	0	22,590,249	0.000000	2,370,906	0	92.00	92.00
93.00 All other Medical Education	0	22,590,249	0.000000	2,370,906	0	93.00	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet D-3

Date/Time Prepared:
11/20/2014 10:57 am

Cost Center Description		Title XVIII		Hospital		PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)			
		1.00	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		1,857,692			30.00
31.00	03100	INTENSIVE CARE UNIT		326,106			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		250,322			34.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.209420	2,467,828	516,813		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240658	712,614	171,496		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.194129	263,090	51,073		55.00
56.00	05600	RADIOISOTOPE	0.157290	23,159	3,643		56.00
57.00	05700	CT SCAN	0.043775	446,941	19,565		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.132082	110,184	14,553		58.00
60.00	06000	LABORATORY	0.201761	1,450,796	292,714		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.288874	591,004	170,726		63.00
64.00	06400	INTRAVENOUS THERAPY	0.204033	11,828	2,413		64.00
65.00	06500	RESPIRATORY THERAPY	0.776065	173,942	134,990		65.00
66.00	06600	PHYSICAL THERAPY	0.713762	166,040	118,513		66.00
69.00	06900	ELECTROCARDIOLOGY	0.131674	180,275	23,738		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.670895	1,464,391	982,453		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.191836	7,168,011	1,375,083		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0		76.00
76.01	03951	HOSPITAL NUTRITION	2.355954	1,870	4,406		76.01
76.02	03952	PAIN MANAGEMENT	0.000000	0	0		76.02
76.03	03954	INFUSION CENTER	0.000000	0	0		76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1.884877	105,601	199,045		90.00
91.00	09100	EMERGENCY	2.418827	11,155	26,982		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.104326	0	0		92.00
200.00		Total (sum of lines 50-94 and 96-98)		15,348,729	4,108,206		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)		15,348,729			202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet E
Part A
Date/Time Prepared:
11/20/2014 10:57 am

		Title XVIII		Hospital		PPS
		0	before 1/1	on/after 1/1	1.01	2.00
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS						
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)		403,426			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		1,020,441			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)		2,556,784			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)		70.17			4.00
Indirect Medical Education Adjustment						
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00			5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00			6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00			7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00			7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00			8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00			8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00			8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00			9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00			10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00			11.00
12.00	Current year allowable FTE (see instructions)		0.00			12.00
13.00	Total allowable FTE count for the prior year.		0.00			13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00			14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00			15.00
16.00	Adjustment for residents in initial years of the program		0.00			16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00			17.00
18.00	Adjusted rolling average FTE count		0.00			18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000			19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000			20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000			21.00
22.00	IME payment adjustment (see instructions)		0			22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00			23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00			24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00			25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000			26.00
27.00	IME payments adjustment 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
Disproportionate Share Adjustment						
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		0.00			30.00
31.00	Percentage of Medicaid patient days (see instructions)		0.00			31.00
32.00	Sum of lines 30 and 31		0.00			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet E
Part A
Date/Time Prepared:
11/20/2014 10:57 am

		Title XVIII		Hospital		PPS
		0	before 1/1	on/after 1/1	2.00	
33.00	Allowable disproportionate share percentage (see instructions)		0.00			33.00
34.00	Disproportionate share adjustment (see instructions)		0			34.00
			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
Uncompensated Care Adjustment						
35.00	Total uncompensated care amount (see instructions)				0	35.00
35.01	Factor 3 (see instructions)				0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)				0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)				0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		0			36.00
Additional payment for high percentage of ESRD beneficiary discharges						
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0			40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0		41.01
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 41.01)		0			46.00
47.00	Subtotal (see instructions)		3,980,651			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0			48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		3,980,651			49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		336,355			50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0			51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0			52.00
53.00	Nursing and Allied Health Managed Care payment		0			53.00
54.00	Special add-on payments for new technologies		0			54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0			55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0			56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30 through 35).		0			57.00
58.00	Ancillary service other pass through costs from Worksheet D, Part IV, col. 11 line 200)		0			58.00
59.00	Total (sum of amounts on lines 49 through 58)		4,317,006			59.00
60.00	Primary payer payments		0			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		4,317,006			61.00
62.00	Deductibles billed to program beneficiaries		103,168			62.00
63.00	Coinsurance billed to program beneficiaries		25,456			63.00
64.00	Allowable bad debts (see instructions)		12,872			64.00
65.00	Adjusted reimbursable bad debts (see instructions)		8,367			65.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet E
Part A
Date/Time Prepared:
11/20/2014 10:57 am

		Title XVIII	Hospital	PPS	
		Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		4,196,749		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS		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)		754		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		0		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)		4,197,503		71.00
71.01	Sequestration adjustment (see instructions)		83,950		71.01
72.00	Interim payments		4,111,388		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		2,165		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0		75.00
TO BE COMPLETED BY CONTRACTOR					
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		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

		Title XVIII			Hospital		PPS
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	0.00	0.00			0.00	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	0.00	0.00			0.00	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	70.17	0.00			70.17	5.00
6.00	Disproportionate Share Payment Percentage (transfer to Worksheet E, Part A, line 33)	0.00	0.00			0.00	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	No				No	7.00
8.00	S-2, Line 22	No				No	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No				No	9.00
10.00	S-2, Line 45	No				No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "y")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	0	0			0	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	0	0			0	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	0	0			0	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	0	0			0	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	12,344	0			12,344	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	12,344	0			12,344	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	0.00	0.00			0.00	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

worksheet DSH

Date/Time Prepared:
11/20/2014 10:57 am

		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	False	0.00		0.00	False	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	True	12.25		0.00	True	29.00
30.00	Line 28 or 29 as applicable		12.25		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		0.00		0.00		31.00
		Original .mcrx values	Adjusted .mcax values	HFS Look Up	Override Value	Revised value	
		1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE							
32.00	Does the hospital qualify under the Pickle ammendment? (worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is this a Rural Referral Center? (worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependat Hospital? (worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Cummunity hospital? (worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet DSH
Date/Time Prepared:
11/20/2014 10:57 am

Title XVIII

Hospital

PPS

Revised
Percentage
6.00

CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE

28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	0.00	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	12.25	29.00
30.00	Line 28 or 29 as applicable	12.25	30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	0.00	31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140100	Period: From 07/01/2013 To 06/30/2014	Worksheet E Part B Date/Time Prepared: 11/20/2014 10:57 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		65,953	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		13,234,818	2.00
3.00	PPS payments		8,673,222	3.00
4.00	Outlier payment (see instructions)		130,753	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)		65,953	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		328,879	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)		328,879	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		328,879	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		262,926	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)		65,953	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		8,803,975	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,591,354	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		7,278,574	27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		7,278,574	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		7,278,574	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		166,534	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		108,247	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		7,386,821	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENT		0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		7,386,821	40.00
40.01	Sequestration adjustment (see instructions)		147,736	40.01
41.00	Interim payments		7,151,549	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		87,536	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00
				Overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet E-1
Part I
Date/Time Prepared:
11/20/2014 10:57 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		4,111,388		7,151,549		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)		4,111,388		7,151,549		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		2,165		87,536		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		4,113,553		7,239,085		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
			0	1.00	2.00		
8.00	Name of Contractor						8.00

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

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet G

Date/Time Prepared:
11/20/2014 10:57 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	0	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	0	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	0	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	0	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	0	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	0	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	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	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	0	0	0	0	45.00
LONG TERM LIABILITIES						
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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	0	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	0				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)	0	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	0	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet G-1

Date/Time Prepared:
11/20/2014 10:57 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		0		0	1.00
2.00	Net income (loss) (from wkst. G-3, line 29)		0			2.00
3.00	Total (sum of line 1 and line 2)		0		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)		0		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)		0		0	19.00

		Endowment Fund	Plant Fund	
		6.00	7.00	8.00
1.00	Fund balances at beginning of period	0		0
2.00	Net income (loss) (from wkst. G-3, line 29)			
3.00	Total (sum of line 1 and line 2)	0		0
4.00	Additions (credit adjustments) (specify)		0	
5.00			0	
6.00			0	
7.00			0	
8.00			0	
9.00			0	
10.00	Total additions (sum of line 4-9)	0		0
11.00	Subtotal (line 3 plus line 10)	0		0
12.00	Deductions (debit adjustments) (specify)		0	
13.00			0	
14.00			0	
15.00			0	
16.00			0	
17.00			0	
18.00	Total deductions (sum of lines 12-17)	0		0
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0

Cost Center Description	Inpatient	Outpatient	Total	
	1.00	2.00	3.00	
PART I - PATIENT REVENUES				
General Inpatient Routine Services				
1.00 Hospital		0	0	1.00
2.00 SUBPROVIDER - IPF				2.00
3.00 SUBPROVIDER - IRF				3.00
4.00 SUBPROVIDER			0	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)	0		0	10.00
Intensive Care Type Inpatient Hospital Services				
11.00 INTENSIVE CARE UNIT		0	0	11.00
12.00 CORONARY CARE UNIT				12.00
13.00 BURN INTENSIVE CARE UNIT	0		0	13.00
14.00 SURGICAL INTENSIVE CARE UNIT				14.00
15.00 OTHER SPECIAL CARE (SPECIFY)			0	15.00
16.00 Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00 Total inpatient routine care services (sum of lines 10 and 16)	0		0	17.00
18.00 Ancillary services	0	0	0	18.00
19.00 Outpatient services	0	0	0	19.00
20.00 RURAL HEALTH CLINIC	0	0	0	20.00
21.00 FEDERALLY QUALIFIED HEALTH CENTER				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULANCE SERVICES				23.00
24.00 CMHC				24.00
25.00 AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00 HOSPICE	0	0	0	26.00
27.00 OTHER (SPECIFY)	0	0	0	27.00
28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	0	0	0	28.00
PART II - OPERATING EXPENSES				
29.00 Operating expenses (per wkst. A, column 3, line 200)		623,182,502		29.00
30.00 REMOVE	-623,182,502			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	-623,182,502		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)		0		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140100

Period:
From 07/01/2013
To 06/30/2014

Worksheet G-3

Date/Time Prepared:
11/20/2014 10:57 am

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

Provider CCN: 140100	Period: From 07/01/2013 To 06/30/2014	Worksheet L Parts I-III Date/Time Prepared: 11/20/2014 10:57 am
Title XVIII	Hospital	PPS

		1.00	
PART I - FULLY PROSPECTIVE METHOD			
CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier	113,587	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	222,768	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)	33.82	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)	336,355	12.00
		1.00	
PART II - PAYMENT UNDER REASONABLE COST			
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
PART III - COMPUTATION OF EXCEPTION PAYMENTS			
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00