

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: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet S Parts I-III Date/Time Prepared: 8/26/2014 5:57 pm
--	----------------------	---	--

<b>PART I - COST REPORT STATUS</b>			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 8/26/2014 Time: 5:57 pm	
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEMORIAL HOSPITAL OF CARBONDALE ( 140164 ) for the cost reporting period beginning 04/01/2013 and ending 03/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	213,076	140,941	36,386	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	6.00
10.00 RURAL HEALTH CLINIC I	0		108,272		0	10.00
200.00 Total	0	213,076	249,213	36,386	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet S-2 Part I Date/Time Prepared: 8/26/2014 5:56 pm
---	--	----------------------	---	---

1.00	2.00	3.00	4.00	1.00
Hospital and Hospital Health Care Complex Address:				
1.00	Street: 405 W. JACKSON ST.	PO Box:		1.00
2.00	City: CARBONDALE	State: IL	Zip Code: 62901	County: JACKSON
				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	MEMORIAL HOSPITAL OF CARBONDALE	140164	99914	1	07/01/1966	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	WEST FRANKFORT FAMILY MEDICINE	143454	99914		11/01/1999	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

						From:	To:
						1.00	2.00

20.00	Cost Reporting Period (mm/dd/yyyy)	04/01/2013	03/31/2014	20.00
21.00	Type of Control (see instructions)	2		21.00

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

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	

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.	8,800	99	1	0	107	1,607	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet S-2 Part I Date/Time Prepared: 8/26/2014 5:56 pm		
		Urban/Rural S	Date of Geogr			
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0			35.00	
		Beginning:	Ending:			
		1.00	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	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N			39.00	
		V	XVII	XIX		
		1.00	2.00	3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N			57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140164		Period: From 04/01/2013 To 03/31/2014		Worksheet S-2 Part I Date/Time Prepared: 8/26/2014 5:56 pm	
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00		61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00		61.20
				1.00			
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
<u>Teaching Hospitals that Claim Residents in Non-Provider Settings</u>							
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)					Y	63.00
				Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	
				Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
				1.00	2.00	3.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	SOUTHERN ILLINOIS FAMILY MEDICINE	1350	9.77	4.69	0.675657	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet S-2 Part I Date/Time Prepared: 8/26/2014 5:56 pm			
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
		1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00		
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	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)	SOUTHERN ILLINOIS FAMILY MEDICINE	1350	10.03	4.97	0.668667 67.00	
				1.00	2.00	3.00	
<b>Inpatient Psychiatric Facility PPS</b>							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N	70.00		
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	71.00	
<b>Inpatient Rehabilitation Facility PPS</b>							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N	75.00		
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	76.00	
				1.00			
<b>Long Term Care Hospital PPS</b>							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00		
<b>TEFRA Providers</b>							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00		
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00		
				V	XIX		
				1.00	2.00		
<b>Title V and XIX Services</b>							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00	
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	95.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet S-2 Part I Date/Time Prepared: 8/26/2014 5:56 pm		
		V	XIX			
		1.00	2.00			
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00		
<b>Rural Providers</b>						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00		
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00		
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00
		1.00	2.00	3.00		
<b>Miscellaneous Cost Reporting Information</b>						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1			118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	4,824,305	0	0		
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N			118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y			121.00
<b>Transplant Center Information</b>						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet S-2 Part I Date/Time Prepared: 8/26/2014 5:56 pm		
		1.00	2.00			
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H124			140.00
		1.00	2.00	3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141.00	Name: SOUTHERN ILLINOIS HEALTHCARE	Contractor's Name: NGS		Contractor's Number: 06101		141.00
142.00	Street: 1239 E MAIN ST	PO Box: 3988				142.00
143.00	City: CARBONDALE	State: IL		Zip Code: 62902-3988		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		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N				147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N				149.00
		Part A		Part B		Title V
		1.00		2.00		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		
Multi campus						
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N				165.00
		Name		County		State
		0		1.00		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
				1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act						
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y				167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0				168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	1.00				169.00
		Beginni ng		Endi ng		
		1.00		2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2012		12/31/2012		170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet S-2 Part II Date/Time Prepared: 8/26/2014 5:56 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	Y			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			Y	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	07/01/2014	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet S-2 Part II Date/Time Prepared: 8/26/2014 5:56 pm	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			Y	27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			Y	35.00
		Y/N	Date		
		1.00	2.00		
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
		1.00	2.00		
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LUANNE	WARREN		41.00
42.00	Enter the employer/company name of the cost report preparer.	SOUTHERN ILLINOIS HEALTHCARE			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	618-457-5200, EXT 67202	LUANNE.WARREN@SIH.NET		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet S-2 Part II Date/Time Prepared: 8/26/2014 5:56 pm
---	--	----------------------	---	--

		Part B		
		Date		
		4.00		
<b>PS&amp;R Data</b>				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	07/01/2014		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		REIMBURSEMENT DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HFS Supplemental Information		Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet S-2 Part IX Date/Time Prepared: 8/26/2014 5:56 pm
		Title V	Title XIX	
		1.00	2.00	
<b>TITLES V AND/OR XIX FOLLOWING MEDICARE</b>				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient	Outpatient	
		1.00	2.00	
<b>CRITICAL ACCESS HOSPITALS</b>				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
<b>RCE DISALLOWANCE</b>				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
<b>PASS THROUGH COST</b>				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140164

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
8/26/2014 5:56 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	133	48,545	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)		133	48,545	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	13	4,745	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 NEONATAL INTENSIVE CARE UNIT	35.00	13	4,745	0.00	0	12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		159	58,035	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	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		159				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)		9	3,285			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140164

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
8/26/2014 5:56 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	14,194	5,677	28,567			1.00
2.00 HMO and other (see instructions)	698	1,715				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)	14,194	5,677	28,567			7.00
8.00 INTENSIVE CARE UNIT	2,028	384	3,827			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 NEONATAL INTENSIVE CARE UNIT	0	1,159	1,644			12.00
13.00 NURSERY		1,679	3,096			13.00
14.00 Total (see instructions)	16,222	8,899	37,134	13.27	1,047.51	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	3,025	5,926	20,542	1.73	12.89	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				15.00	1,060.40	27.00
28.00 Observation Bed Days		882	3,957			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	445	1,018			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140164

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
8/26/2014 5:56 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	4,186	2,241	10,155	1.00
2.00 HMO and other (see instructions)			197			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 NEONATAL INTENSIVE CARE UNIT						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	4,186	2,241	10,155	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						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	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
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: 140164		Period: From 04/01/2013 To 03/31/2014		Worksheet S-3 Part II Date/Time Prepared: 8/26/2014 5:56 pm		
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)			
	1.00	2.00	3.00	4.00	5.00	6.00			
<b>PART II - WAGE DATA</b>									
<b>SALARIES</b>									
1.00	Total salaries (see instructions)	200.00	56,938,470	0	56,938,470	2,205,632.21	25.82		
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		459,561	0	459,561	27,980.99	16.42		
6.00	Non-physician-Part B		0	0	0	0.00	0.00		
7.00	Interns & residents (in an approved program)	21.00	998,882	0	998,882	37,776.00	26.44		
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)		4,228	-4,228	0	0.00	0.00		
<b>OTHER WAGES &amp; RELATED COSTS</b>									
11.00	Contract labor (see instructions)		2,692,355	0	2,692,355	46,611.35	57.76		
12.00	Contract management and administrative services		0	0	0	0.00	0.00		
13.00	Contract Labor: Physician-Part A - Administrative		582,883	0	582,883	3,265.00	178.52		
14.00	Home office salaries & wage-related costs		12,812,847	0	12,812,847	301,823.66	42.45		
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00		
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00		
<b>WAGE-RELATED COSTS</b>									
17.00	Wage-related costs (core) (see instructions)		17,363,059	0	17,363,059				
18.00	Wage-related costs (other) (see instructions)		0	0	0				
19.00	Excluded areas		0	0	0				
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		16,195	0	16,195				
24.00	Wage-related costs (RHC/FOHC)		127,629	0	127,629				
25.00	Interns & residents (in an approved program)		312,611	0	312,611				
<b>OVERHEAD COSTS - DIRECT SALARIES</b>									
26.00	Employee Benefits Department	4.00	268,987	0	268,987	10,461.21	25.71		
27.00	Administrative & General	5.00	3,403,377	0	3,403,377	151,652.53	22.44		
28.00	Administrative & General under contract (see inst.)		151,474	0	151,474	608.85	248.79		
29.00	Maintenance & Repairs	6.00	682,949	0	682,949	30,733.42	22.22		
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00		
31.00	Laundry & Linen Service	8.00	42,510	0	42,510	3,628.97	11.71		
32.00	Housekeeping	9.00	974,009	0	974,009	81,214.80	11.99		
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00		
34.00	Dietary	10.00	1,396,979	-1,059,667	337,312	23,366.34	14.44		
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00		
36.00	Cafeteria	11.00	0	1,059,667	1,059,667	73,388.71	14.44		
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00		
38.00	Nursing Administration	13.00	1,047,665	0	1,047,665	26,156.73	40.05		
39.00	Central Services and Supply	14.00	851,375	0	851,375	59,649.70	14.27		
40.00	Pharmacy	15.00	0	0	0	0.00	0.00		
41.00	Medical Records & Medical Records Library	16.00	533,025	0	533,025	35,663.84	14.95		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140164

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
8/26/2014 5:56 pm

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

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140164

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
8/26/2014 5:56 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	55,631,501	0	55,631,501	2,140,484.07	25.99	1.00
2.00	Excluded area salaries (see instructions)	4,228	-4,228	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	55,627,273	4,228	55,631,501	2,140,484.07	25.99	3.00
4.00	Subtotal other wages & related costs (see inst.)	16,088,085	0	16,088,085	351,700.01	45.74	4.00
5.00	Subtotal wage-related costs (see inst.)	17,363,059	0	17,363,059	0.00	31.21	5.00
6.00	Total (sum of lines 3 thru 5)	89,078,417	4,228	89,082,645	2,492,184.08	35.74	6.00
7.00	Total overhead cost (see instructions)	9,352,350	0	9,352,350	496,525.10	18.84	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet S-3 Part IV Date/Time Prepared: 8/26/2014 5:56 pm
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions			1,042,087 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration Fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)			10,534,903 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			56,467 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			27,419 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			0 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			200,791 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			713,975 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			722,373 16.00
<b>TAXES</b>				
17.00	FICA-Employers Portion Only			4,201,237 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			29,054 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			122,175 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			169,013 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			17,819,494 24.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet S-3 Part V Date/Time Prepared: 8/26/2014 5:56 pm
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
<b>PART V - Contract Labor and Benefit Cost</b>				
<b>Hospital and Hospital-Based Component Identification:</b>				
1.00	Total facility's contract labor and benefit cost		2,692,355	17,819,494
2.00	Hospital		2,692,355	17,819,494
3.00	Subprovider - IPF			
4.00	Subprovider - IRF			
5.00	Subprovider - (Other)		0	0
6.00	Swing Beds - SNF		0	0
7.00	Swing Beds - NF		0	0
8.00	Hospital-Based SNF			
9.00	Hospital-Based NF			
10.00	Hospital-Based OLTC			
11.00	Hospital-Based HHA			
12.00	Separately Certified ASC			
13.00	Hospital-Based Hospice			
14.00	Hospital-Based Health Clinic RHC		0	0
15.00	Hospital-Based Health Clinic FQHC			
16.00	Hospital-Based-CMHC			
17.00	Renal Dialysis			
18.00	Other		0	0

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140164 Component CCN: 143454	Period: From 04/01/2013 To 03/31/2014	Worksheet S-8 Date/Time Prepared: 8/26/2014 5:56 pm			
			Rural Health Clinic (RHC) I	Cost			
				1.00			
1.00	Clinic Address and Identification Street		2553 KEN GRAY BOULEVARD				
		City	State	Zip Code			
		1.00	2.00	3.00			
2.00	City, State, Zip Code, County		WEST FRANKFORT IL 62896				
				1.00			
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0			
			Grant Award	Date			
			1.00	2.00			
Source of Federal Funds							
4.00	Community Health Center (Section 330(d), PHS Act)			0			
5.00	Migrant Health Center (Section 329(d), PHS Act)			0			
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0			
7.00	Appalachian Regional Commission			0			
8.00	Look-Alikes			0			
9.00	OTHER (SPECIFY)			0			
				1.00			
10.00	Does this facility operate as other than an RHC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N			
			1.00	2.00			
Facility hours of operations (1)							
		Sunday		Monday	Tuesday		
		from	to	from	to		
		1.00	2.00	3.00	4.00		
11.00	Clinic		08:00	17:00	08:00		
				1.00	2.00		
12.00	Have you received an approval for an exception to the productivity standard?			N			
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N			
			1.00	2.00			
			Provider name	CCN number			
			1.00	2.00			
14.00	Provider name, CCN number						
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		Y	0	651	733	1,939
			County				
			4.00				
2.00	City, State, Zip Code, County		FRANKLIN				
		Tuesday		Wednesday		Thursday	
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)							
11.00	Clinic		17:00	08:00	17:00	08:00	17:00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140164 Component CCN: 143454	Period: From 04/01/2013 To 03/31/2014	Worksheet S-8 Date/Time Prepared: 8/26/2014 5:56 pm	
			Rural Health Clinic (RHC) I	Cost	
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
11.00	Facility hours of operations (1) Clinic	08:00	17:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet S-10 Date/Time Prepared: 8/26/2014 5:56 pm
---	----------------------	---	--

			1.00			
<b>Uncompensated and indigent care cost computation</b>						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.272482	1.00		
<b>Medicaid (see instructions for each line)</b>						
2.00	Net revenue from Medicaid		14,449,986	2.00		
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00		
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N	4.00		
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		2,345,216	5.00		
6.00	Medicaid charges		113,653,353	6.00		
7.00	Medicaid cost (line 1 times line 6)		30,968,493	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)		14,173,291	8.00		
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>						
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		
<b>Other state or local government indigent care program (see instructions for each line)</b>						
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		
<b>Uncompensated care (see instructions for each line)</b>						
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		348,051	18.00		
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		14,173,291	19.00		
			Uninsured patients	Insured patients		
			1.00	2.00		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility		23,172,790	2,325,487	25,498,277	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)		6,314,168	633,653	6,947,821	21.00
22.00	Partial payment by patients approved for charity care		0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)		6,314,168	633,653	6,947,821	23.00
			1.00			
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?					24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit				0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)				16,537,649	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)				1,293,565	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)				15,244,084	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)				4,153,738	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				11,101,559	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)				25,274,850	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 140164		Period: From 04/01/2013 To 03/31/2014		Worksheet A	
Date/Time Prepared: 8/26/2014 5:56 pm							
Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
	1.00	2.00	3.00	4.00	5.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	CAP REL COSTS-BLDG & FIXT		4,199,107	4,199,107	360,408	4,559,515	1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		5,189,290	5,189,290	194,066	5,383,356	2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	268,987	21,403,291	21,672,278	0	21,672,278	4.00
5.02 00551	DATA PROCESSING	0	0	0	0	0	5.02
5.03 00560	PURCHASING RECEIVING AND STORES	0	109,050	109,050	-142	108,908	5.03
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	672,655	76,420	749,075	0	749,075	5.05
5.06 00590	OTHER ADMINISTRATIVE AND GENERAL	2,730,722	19,440,870	22,171,592	-659	22,170,933	5.06
6.00 00600	MAINTENANCE & REPAIRS	682,949	1,764,580	2,447,529	0	2,447,529	6.00
8.00 00800	LAUNDRY & LINEN SERVICE	42,510	1,211,371	1,253,881	0	1,253,881	8.00
9.00 00900	HOUSEKEEPING	974,009	620,269	1,594,278	0	1,594,278	9.00
10.00 01000	DIETARY	1,396,979	1,129,652	2,526,631	-1,929,779	596,852	10.00
11.00 01100	CAFETERIA	0	0	0	1,916,555	1,916,555	11.00
13.00 01300	NURSING ADMINISTRATION	1,047,665	51,837	1,099,502	-550	1,098,952	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	851,375	435,898	1,287,273	-15,056	1,272,217	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	533,025	76,512	609,537	0	609,537	16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	2,609,569	2,609,569	19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	998,882	0	998,882	0	998,882	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	918,693	918,693	0	918,693	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	12,906,257	6,645,858	19,552,115	-51,597	19,500,518	30.00
31.00 03100	INTENSIVE CARE UNIT	2,894,074	721,665	3,615,739	-54,234	3,561,505	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	1,047,005	648,378	1,695,383	0	1,695,383	35.00
43.00 04300	NURSERY	46,906	162,638	209,544	-1,562	207,982	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	2,991,390	17,791,227	20,782,617	-11,178,590	9,604,027	50.00
50.01 03020	SAME DAY SURGERY	1,923,918	855,815	2,779,733	-2,779,733	0	50.01
51.00 05100	RECOVERY ROOM	662,112	37,152	699,264	-2,607	696,657	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,606,821	401,006	4,007,827	-13,759	3,994,068	52.00
53.00 05300	ANESTHESIOLOGY	0	3,285,855	3,285,855	-2,793,514	492,341	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,820,867	1,754,042	4,574,909	-654,667	3,920,242	54.00
54.01 03480	ONCOLOGY	952,511	1,496,043	2,448,554	-5,969	2,442,585	54.01
54.02 03440	MAMMOGRAPHY	636,700	615,269	1,251,969	-112,726	1,139,243	54.02
56.00 05600	RADIOISOTOPE	333,965	735,545	1,069,510	272,897	1,342,407	56.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	201,663	58,268	259,931	-48,707	211,224	58.00
59.00 05900	CARDIAC CATHETERIZATION	2,664,152	15,308,608	17,972,760	-9,472,213	8,500,547	59.00
60.00 06000	LABORATORY	2,339,081	4,544,323	6,883,404	-38,512	6,844,892	60.00
65.00 06500	RESPIRATORY THERAPY	1,242,163	449,333	1,691,496	-100,301	1,591,195	65.00
66.00 06600	PHYSICAL THERAPY	1,922,092	846,530	2,768,622	-180	2,768,442	66.00
69.00 06900	ELECTROCARDIOLOGY	1,117,314	6,565,997	7,683,311	-452,169	7,231,142	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	97,295	168,196	265,491	-25,846	239,645	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10,544,967	10,544,967	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	13,947,988	13,947,988	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2,532,662	5,470,436	8,003,098	470,270	8,473,368	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800	RURAL HEALTH CLINIC	407,813	901,590	1,309,403	-4,762	1,304,641	88.00
91.00 09100	EMERGENCY	3,387,723	3,521,503	6,909,226	-15,026	6,894,200	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00 11300	INTEREST EXPENSE		4,214,142	4,214,142	-554,474	3,659,668	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	56,934,242	133,826,259	190,760,501	9,386	190,769,887	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	105,079	105,079	0	105,079	192.00
192.01 19201	FAMILY PRACTICE	0	0	0	0	0	192.01
192.02 19202	REFERENCE LAB	4,228	5,158	9,386	-9,386	0	192.02
192.03 19203	UNUSED SPACE	0	0	0	0	0	192.03
200.00	TOTAL (SUM OF LINES 118-199)	56,938,470	133,936,496	190,874,966	0	190,874,966	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140164

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

Worksheet A  
Date/Time Prepared:  
8/26/2014 5:56 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	43,284	4,602,799	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	5,174,995	10,558,351	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,734,823	23,407,101	4.00
5.02	00551	DATA PROCESSING	5,326,224	5,326,224	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	-6,248	102,660	5.03
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	3,637,927	4,387,002	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	-4,060,356	18,110,577	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	2,447,529	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,253,881	8.00
9.00	00900	HOUSEKEEPING	-270	1,594,008	9.00
10.00	01000	DIETARY	0	596,852	10.00
11.00	01100	CAFETERIA	-959,371	957,184	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,098,952	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,272,217	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-75,933	533,604	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-2,609,569	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	998,882	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	-924	917,769	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-2,658,025	16,842,493	30.00
31.00	03100	INTENSIVE CARE UNIT	-21,760	3,539,745	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	-586,970	1,108,413	35.00
43.00	04300	NURSERY	0	207,982	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-427,917	9,176,110	50.00
50.01	03020	SAME DAY SURGERY	0	0	50.01
51.00	05100	RECOVERY ROOM	0	696,657	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,994,068	52.00
53.00	05300	ANESTHESIOLOGY	0	492,341	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-4,810	3,915,432	54.00
54.01	03480	ONCOLOGY	-532,322	1,910,263	54.01
54.02	03440	MAMMOGRAPHY	-35,045	1,104,198	54.02
56.00	05600	RADIOISOTOPE	0	1,342,407	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	211,224	58.00
59.00	05900	CARDIAC CATHETERIZATION	-63,387	8,437,160	59.00
60.00	06000	LABORATORY	-71,500	6,773,392	60.00
65.00	06500	RESPIRATORY THERAPY	-4,786	1,586,409	65.00
66.00	06600	PHYSICAL THERAPY	-46,737	2,721,705	66.00
69.00	06900	ELECTROCARDIOLOGY	-207,827	7,023,315	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-6,000	233,645	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,544,967	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	13,947,988	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,473,368	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	-29,136	1,275,505	88.00
91.00	09100	EMERGENCY	-2,604,434	4,289,766	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	-3,659,668	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,755,742	188,014,145	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	105,079	192.00
192.01	19201	FAMILY PRACTICE	0	0	192.01
192.02	19202	REFERENCE LAB	0	0	192.02
192.03	19203	UNUSED SPACE	0	0	192.03
200.00		TOTAL (SUM OF LINES 118-199)	-2,755,742	188,119,224	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 140164

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

Worksheet Non-CMS W  
Date/Time Prepared:  
8/26/2014 5:56 pm

Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
	1.00	2.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00 CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00 EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.02 DATA PROCESSING	00551		5.02
5.03 PURCHASING RECEIVING AND STORES	00560		5.03
5.05 CASHIERING/ACCOUNTS RECEIVABLE	00580		5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	00590		5.06
6.00 MAINTENANCE & REPAIRS	00600		6.00
8.00 LAUNDRY & LINEN SERVICE	00800		8.00
9.00 HOUSEKEEPING	00900		9.00
10.00 DIETARY	01000		10.00
11.00 CAFETERIA	01100		11.00
13.00 NURSING ADMINISTRATION	01300		13.00
14.00 CENTRAL SERVICES & SUPPLY	01400		14.00
16.00 MEDICAL RECORDS & LIBRARY	01600		16.00
19.00 NONPHYSICIAN ANESTHETISTS	01900		19.00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD	02100		21.00
22.00 I&R SERVICES-OTHER PRGM COSTS APPRVD	02200		22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00 ADULTS & PEDIATRICS	03000		30.00
31.00 INTENSIVE CARE UNIT	03100		31.00
35.00 NEONATAL INTENSIVE CARE UNIT	02060		35.00
43.00 NURSERY	04300		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 OPERATING ROOM	05000		50.00
50.01 SAME DAY SURGERY	03020		50.01
51.00 RECOVERY ROOM	05100		51.00
52.00 DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00 ANESTHESIOLOGY	05300		53.00
54.00 RADIOLOGY-DIAGNOSTIC	05400		54.00
54.01 ONCOLOGY	03480		54.01
54.02 MAMMOGRAPHY	03440		54.02
56.00 RADIOISOTOPE	05600		56.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
59.00 CARDIAC CATHETERIZATION	05900		59.00
60.00 LABORATORY	06000		60.00
65.00 RESPIRATORY THERAPY	06500		65.00
66.00 PHYSICAL THERAPY	06600		66.00
69.00 ELECTROCARDIOLOGY	06900		69.00
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
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00 RURAL HEALTH CLINIC	08800		88.00
91.00 EMERGENCY	09100		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00 INTEREST EXPENSE	11300		113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)			118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00 PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.01 FAMILY PRACTICE	19201		192.01
192.02 REFERENCE LAB	19202		192.02
192.03 UNUSED SPACE	19203		192.03
200.00 TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS

Provider CCN: 140164

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

Worksheet A-6  
Date/Time Prepared:  
8/26/2014 5:56 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - DIETARY RECLASS</b>					
1.00	CAFETERIA	11.00	1,059,667	856,888	1.00
	TOTALS		1,059,667	856,888	
<b>B - NUTRITIONAL PRODUCT RECLASS</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	99,954	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
	TOTALS		0	99,954	
<b>C - MEDICAL SUPPLY RECLASS</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	24,492,955	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
	TOTALS		0	24,492,955	
<b>D - REFERENCE LAB RECLASS</b>					
1.00	LABORATORY	60.00	4,228	5,158	1.00
	TOTALS		4,228	5,158	
<b>E - SAME DAY SURGERY</b>					
1.00	OPERATING ROOM	50.00	1,923,918	855,815	1.00
	TOTALS		1,923,918	855,815	
<b>F - INTEREST RECLASS</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	360,408	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	194,066	2.00
	TOTALS		0	554,474	
<b>G - IMPLANTABLE DEVICE RECLASS</b>					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	13,947,988	1.00
	TOTALS		0	13,947,988	
<b>H - CRNA RECLASS</b>					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	2,609,569	1.00
	TOTALS		0	2,609,569	
<b>I - CONTRAST DRUG RECLASS</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	370,316	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	TOTALS		0	370,316	
<b>J - ISOTOPE RECLASS</b>					
1.00	RADIOISOTOPE	56.00	0	273,071	1.00
	TOTALS		0	273,071	
500.00	Grand Total: Increases		2,987,813	44,066,188	500.00

RECLASSIFICATIONS

Provider CCN: 140164

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

Worksheet A-6  
Date/Time Prepared:  
8/26/2014 5:56 pm

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
<b>A - DIETARY RECLASS</b>							
1.00	DIETARY	10.00	1,059,667	856,888	0		1.00
	TOTALS		1,059,667	856,888			
<b>B - NUTRITIONAL PRODUCT RECLASS</b>							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,257	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	28,187	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	8,617	0		3.00
4.00	NURSERY	43.00	0	1,376	0		4.00
5.00	OPERATING ROOM	50.00	0	10,680	0		5.00
6.00	RECOVERY ROOM	51.00	0	2,332	0		6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	7,978	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	10,704	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	709	0		9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	5,549	0		10.00
11.00	RADIOISOTOPE	56.00	0	174	0		11.00
12.00	LABORATORY	60.00	0	43	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	497	0		13.00
14.00	EMERGENCY	91.00	0	7,426	0		14.00
15.00	MAMMOGRAPHY	54.02	0	201	0		15.00
16.00	DIETARY	10.00	0	13,224	0		16.00
	TOTALS		0	99,954			
<b>C - MEDICAL SUPPLY RECLASS</b>							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	12,799	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	23,410	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	45,617	0		3.00
4.00	NURSERY	43.00	0	186	0		4.00
5.00	OPERATING ROOM	50.00	0	13,947,643	0		5.00
6.00	RECOVERY ROOM	51.00	0	275	0		6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	5,781	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	173,241	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	613,102	0		9.00
10.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	112	0		10.00
11.00	CARDIAC CATHETERIZATION	59.00	0	9,353,844	0		11.00
12.00	LABORATORY	60.00	0	47,855	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	100,301	0		13.00
14.00	EMERGENCY	91.00	0	7,600	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	10,556	0		15.00
16.00	ELECTROENCEPHALOGRAPHY	70.00	0	25,846	0		16.00
17.00	MAMMOGRAPHY	54.02	0	112,525	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	180	0		18.00
19.00	ONCOLOGY	54.01	0	5,969	0		19.00
20.00	RURAL HEALTH CLINIC	88.00	0	4,762	0		20.00
21.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	659	0		21.00
22.00	NURSING ADMINISTRATION	13.00	0	550	0		22.00
23.00	PURCHASING RECEIVING AND STORES	5.03	0	142	0		23.00
	TOTALS		0	24,492,955			
<b>D - REFERENCE LAB RECLASS</b>							
1.00	REFERENCE LAB	192.02	4,228	5,158	0		1.00
	TOTALS		4,228	5,158			
<b>E - SAME DAY SURGERY</b>							
1.00	SAME DAY SURGERY	50.01	1,923,918	855,815	0		1.00
	TOTALS		1,923,918	855,815			
<b>F - INTEREST RECLASS</b>							
1.00	INTEREST EXPENSE	113.00	0	554,474	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	554,474			
<b>G - IMPLANTABLE DEVICE RECLASS</b>							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	13,947,988	0		1.00
	TOTALS		0	13,947,988			
<b>H - CRNA RECLASS</b>							
1.00	ANESTHESIOLOGY	53.00	0	2,609,569	0		1.00
	TOTALS		0	2,609,569			
<b>I - CONTRAST DRUG RECLASS</b>							
1.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	48,595	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	168,045	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	40,856	0		3.00
4.00	CARDIAC CATHETERIZATION	59.00	0	112,820	0		4.00
	TOTALS		0	370,316			

RECLASSIFICATIONS

Provider CCN: 140164

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

Worksheet A-6  
Date/Time Prepared:  
8/26/2014 5:56 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
J - ISOTOPE RECLASS							
1.00	ELECTROCARDIOLOGY	69.00	0	273,071	0		1.00
	TOTALS		0	273,071			
500.00	Grand Total: Decreases		2,987,813	44,066,188			500.00

RECLASSIFICATIONS

Provider CCN: 140164

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

Worksheet A-6  
Non-CMS Worksheet  
Date/Time Prepared:  
8/26/2014 5:56 pm

Increases			Decreases			
Cost Center	Line #	Salary	Cost Center	Line #	Salary	
2.00	3.00	4.00	6.00	7.00	8.00	
<b>A - DIETARY RECLASS</b>						
1.00	CAFETERIA	11.00	1,059,667	DIETARY	10.00	1,059,667
	TOTALS		1,059,667	TOTALS		1,059,667
<b>B - NUTRITIONAL PRODUCT RECLASS</b>						
1.00	DRUGS CHARGED TO PATIENTS	73.00		CENTRAL SERVICES & SUPPLY	14.00	
2.00		0.00		ADULTS & PEDIATRICS	30.00	
3.00		0.00		INTENSIVE CARE UNIT	31.00	
4.00		0.00		NURSERY	43.00	
5.00		0.00		OPERATING ROOM	50.00	
6.00		0.00		RECOVERY ROOM	51.00	
7.00		0.00		DELIVERY ROOM & LABOR ROOM	52.00	
8.00		0.00		ANESTHESIOLOGY	53.00	
9.00		0.00		RADIOLOGY-DIAGNOSTIC	54.00	
10.00		0.00		CARDIAC CATHETERIZATION	59.00	
11.00		0.00		RADIOISOTOPE	56.00	
12.00		0.00		LABORATORY	60.00	
13.00		0.00		ELECTROCARDIOLOGY	69.00	
14.00		0.00		EMERGENCY	91.00	
15.00		0.00		MAMMOGRAPHY	54.02	
16.00		0.00		DIETARY	10.00	
	TOTALS			TOTALS		
<b>C - MEDICAL SUPPLY RECLASS</b>						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		CENTRAL SERVICES & SUPPLY	14.00	
2.00		0.00		ADULTS & PEDIATRICS	30.00	
3.00		0.00		INTENSIVE CARE UNIT	31.00	
4.00		0.00		NURSERY	43.00	
5.00		0.00		OPERATING ROOM	50.00	
6.00		0.00		RECOVERY ROOM	51.00	
7.00		0.00		DELIVERY ROOM & LABOR ROOM	52.00	
8.00		0.00		ANESTHESIOLOGY	53.00	
9.00		0.00		RADIOLOGY-DIAGNOSTIC	54.00	
10.00		0.00		MAGNETIC RESONANCE IMAGING (MRI)	58.00	
11.00		0.00		CARDIAC CATHETERIZATION	59.00	
12.00		0.00		LABORATORY	60.00	
13.00		0.00		RESPIRATORY THERAPY	65.00	
14.00		0.00		EMERGENCY	91.00	
15.00		0.00		ELECTROCARDIOLOGY	69.00	
16.00		0.00		ELECTROENCEPHALOGRAPHY	70.00	
17.00		0.00		MAMMOGRAPHY	54.02	
18.00		0.00		PHYSICAL THERAPY	66.00	
19.00		0.00		ONCOLOGY	54.01	
20.00		0.00		RURAL HEALTH CLINIC	88.00	
21.00		0.00		OTHER ADMINISTRATIVE AND GENERAL	5.06	
22.00		0.00		NURSING ADMINISTRATION	13.00	
23.00		0.00		PURCHASING RECEIVING AND STORES	5.03	
	TOTALS			TOTALS		
<b>D - REFERENCE LAB RECLASS</b>						
1.00	LABORATORY	60.00	4,228	REFERENCE LAB	192.02	4,228
	TOTALS		4,228	TOTALS		4,228
<b>E - SAME DAY SURGERY</b>						
1.00	OPERATING ROOM	50.00	1,923,918	SAME DAY SURGERY	50.01	1,923,918
	TOTALS		1,923,918	TOTALS		1,923,918
<b>F - INTEREST RECLASS</b>						
1.00	CAP REL COSTS-BLDG & FIXT	1.00		INTEREST EXPENSE	113.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00			0.00	
	TOTALS			TOTALS		
<b>G - IMPLANTABLE DEVICE RECLASS</b>						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	
	TOTALS			TOTALS		
<b>H - CRNA RECLASS</b>						
1.00	NONPHYSICIAN ANESTHETISTS	19.00		ANESTHESIOLOGY	53.00	
	TOTALS			TOTALS		
<b>I - CONTRAST DRUG RECLASS</b>						
1.00	DRUGS CHARGED TO PATIENTS	73.00		MAGNETIC RESONANCE IMAGING (MRI)	58.00	
2.00		0.00		ELECTROCARDIOLOGY	69.00	
3.00		0.00		RADIOLOGY-DIAGNOSTIC	54.00	
4.00		0.00		CARDIAC CATHETERIZATION	59.00	
	TOTALS			TOTALS		

RECLASSIFICATIONS

Provider CCN: 140164

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

Worksheet A-6  
Non-CMS Worksheet  
Date/Time Prepared:  
8/26/2014 5:56 pm

	Increases			Decreases			
	Cost Center	Line #	Salary	Cost Center	Line #	Salary	
	2.00	3.00	4.00	6.00	7.00	8.00	
	J - ISOTOPE RECLASS						
1.00	RADIOISOTOPE	56.00		ELECTROCARDIOLOGY	69.00		1.00
	TOTALS			TOTALS			0
500.00	Grand Total: Increases			Grand Total: Decreases			500.00
			2,987,813			2,987,813	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140164

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
8/26/2014 5:56 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	5,842,191	95,309	0	95,309	0	1.00
2.00	Land Improvements	3,444,373	61,131	0	61,131	77,741	2.00
3.00	Buildings and Fixtures	55,553,845	1,632,139	0	1,632,139	36,485	3.00
4.00	Building Improvements	48,163,632	566,816	0	566,816	189,558	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	59,392,699	5,606,083	0	5,606,083	6,672,604	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	172,396,740	7,961,478	0	7,961,478	6,976,388	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	172,396,740	7,961,478	0	7,961,478	6,976,388	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	5,937,500	0				1.00
2.00	Land Improvements	3,427,763	0				2.00
3.00	Buildings and Fixtures	57,149,499	0				3.00
4.00	Building Improvements	48,540,890	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	58,326,178	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	173,381,830	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	173,381,830	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140164

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
8/26/2014 5:56 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	4,199,107	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,189,290	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	9,388,397	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	4,199,107				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,189,290				2.00
3.00	Total (sum of lines 1-2)	0	9,388,397				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140164

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
8/26/2014 5:56 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	115,055,651	0	115,055,651	0.663789	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	58,275,930	0	58,275,930	0.336211	0	2.00
3.00	Total (sum of lines 1-2)	173,331,581	0	173,331,581	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	4,602,799	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	10,558,351	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	15,161,150	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	4,602,799	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	10,558,351	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	15,161,150	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140164

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

Worksheet A-8

Date/Time Prepared:  
8/26/2014 5:56 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted					
			Cost Center	Line #	Wkst.	A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)			0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00		0	7.00
8.00 Television and radio service (chapter 21)			0		0.00		0	8.00
9.00 Parking lot (chapter 21)			0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-7,158,363					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	28,765,456					0	12.00
13.00 Laundry and linen service			0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-941,186	CAFETERIA		11.00		0	14.00
15.00 Rental of quarters to employee and others			0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00		0	16.00
17.00 Sale of drugs to other than patients			0		0.00		0	17.00
18.00 Sale of medical records and abstracts	B	-61,550	MEDICAL RECORDS & LIBRARY		16.00		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00		0	19.00
20.00 Vending machines	B	-18,185	CAFETERIA		11.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist	A	-2,609,569	NONPHYSICIAN ANESTHETISTS		19.00		0	28.00
29.00 Physicians' assistant			0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00		0	32.00
33.00 EMPLOYEE OUTPATIENT PAYMENTS	B	-3,273,644	EMPLOYEE BENEFITS DEPARTMENT		4.00		0	33.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
34.00 DEBT FORGIVENESS	A	-8,224,174	OTHER ADMINISTRATIVE AND GENERAL	5.06	0 34.00
35.00 TELEVISION AND RADIO SERVICES	A	-6,660	CAP REL COSTS-MVBLE EQUIP	2.00	9 35.00
36.00 INTEREST INCOME UNRESTRICTED	B	-1,394,596	OTHER ADMINISTRATIVE AND GENERAL	5.06	0 36.00
37.00 LOSS ON 1994 BONDS	A	162,945	CAP REL COSTS-BLDG & FIXT	1.00	9 37.00
38.00 LOSS ON 1994 BONDS	A	139,758	CAP REL COSTS-MVBLE EQUIP	2.00	9 38.00
39.00 FUNDED DEPRECIATION	A	-6,977	CAP REL COSTS-BLDG & FIXT	1.00	9 39.00
40.00 NONALLOWABLE BOND EXPENSE	A	-3,659,668	INTEREST EXPENSE	113.00	0 40.00
41.00 MISCELLANEOUS INCOME	B	-13,243	OTHER ADMINISTRATIVE AND GENERAL	5.06	0 41.00
42.00 SALE OF XRAY SILVER/FILM	B	-1,676	RADIOLOGY-DIAGNOSTIC	54.00	0 42.00
43.00 OFFSET LOBBYING EXPENSES	A	-31,973	OTHER ADMINISTRATIVE AND GENERAL	5.06	0 43.00
44.00 PURCHASE DISCOUNT	B	-6,248	PURCHASING RECEIVING AND STORES	5.03	0 44.00
45.00 LOSS ON 1987 BONDS	A	85,552	CAP REL COSTS-BLDG & FIXT	1.00	9 45.00
46.00 LOSS ON 1987 BONDS	A	29,623	CAP REL COSTS-MVBLE EQUIP	2.00	9 46.00
47.00 LOSS ON 1991 BONDS	A	186,388	CAP REL COSTS-BLDG & FIXT	1.00	9 47.00
48.00 LOSS ON 1991 BONDS	A	127,555	CAP REL COSTS-MVBLE EQUIP	2.00	9 48.00
49.00 LEASEHOLD REVENUE	B	-25,068	MAMMOGRAPHY	54.02	0 49.00
49.01 VENDING MACHINE INCOME	B	-270	HOUSEKEEPING	9.00	0 49.01
49.02 EKG MEDICAL DIRECTOR	A	-275	ELECTROCARDIOLOGY	69.00	0 49.02
49.03 PATIENT'S GUEST LODGING EXPENSE	A	-48,469	CARDIAC CATHETERIZATION	59.00	0 49.03
49.04 LEASEHOLD REVENUE	B	-509,162	CAP REL COSTS-BLDG & FIXT	1.00	9 49.04
49.05 MEDICAID PROVIDER TAX	A	-4,220,412	OTHER ADMINISTRATIVE AND GENERAL	5.06	0 49.05
49.06 CABLE TV	A	-924	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0 49.06
49.07 MISCELLANEOUS INCOME	B	-2,400	LABORATORY	60.00	0 49.07
49.08 PERSONAL PORTION OF PROVIDER VEHICLE	A	-8,042	OTHER ADMINISTRATIVE AND GENERAL	5.06	0 49.08
49.09 SALE OF MEDICAL RECORDS AND ABSTRACT	B	-640	RURAL HEALTH CLINIC	88.00	0 49.09
49.10 MISCELLANEOUS INCOME	B	-27,804	RURAL HEALTH CLINIC	88.00	0 49.10
49.11 INTEREST INCOME UNRESTRICTED	B	-692	RURAL HEALTH CLINIC	88.00	0 49.11
49.12 VENDING MACHINE INCOME	B	-657	ELECTROCARDIOLOGY	69.00	0 49.12
49.13 ALCOHOL PURCHASES	A	-425	OTHER ADMINISTRATIVE AND GENERAL	5.06	0 49.13
49.14 ALCOHOL PURCHASES	A	-47	CARDIAC CATHETERIZATION	59.00	0 49.14
49.15 ALCOHOL PURCHASES	A	-20	ELECTROCARDIOLOGY	69.00	0 49.15
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,755,742			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: 140164

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

Worksheet A-8-1

Date/Time Prepared: 8/26/2014 5:56 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE EXPENSE	124,538	0
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE EXPENSE	4,884,719	0
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE EXPENSE	5,008,467	0
4.00	5.02	DATA PROCESSING	HOME OFFICE EXPENSE	5,326,224	0
4.01	5.05	CASHIERING/ACCOUNTS RECEIVAB	HOME OFFICE EXPENSE	3,637,927	0
4.02	5.06	OTHER ADMINISTRATIVE AND GEN	HOME OFFICE EXPENSE	9,857,761	0
4.03	66.00	PHYSICAL THERAPY	RENT	89,691	136,428
4.04	5.06	OTHER ADMINISTRATIVE AND GEN	RENT	3,957	13,883
4.05	16.00	MEDICAL RECORDS & LIBRARY	RENT	15,500	29,883
4.06	54.00	RADIOLOGY-DIAGNOSTIC	RENT	3,558	6,692
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			28,952,342	186,886

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

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

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

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

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

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

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

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

Provider CCN: 140164

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

Worksheet A-8-1

Date/Time Prepared:  
8/26/2014 5:56 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	124,538	9		1.00
2.00	4,884,719	9		2.00
3.00	5,008,467	0		3.00
4.00	5,326,224	0		4.00
4.01	3,637,927	0		4.01
4.02	9,857,761	0		4.02
4.03	-46,737	0		4.03
4.04	-9,926	0		4.04
4.05	-14,383	0		4.05
4.06	-3,134	0		4.06
5.00	28,765,456			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140164

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

Worksheet A-8-2

Date/Time Prepared:  
8/26/2014 5:56 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	DR. A	2,658,025	2,658,025	0	0	0	1.00
2.00	31.00	DR. B	53,105	0	53,105	159,800	408	2.00
3.00	35.00	DR. C	605,562	557,162	48,400	159,800	242	3.00
4.00	50.00	DR. D	428,796	425,331	3,465	182,900	10	4.00
5.00	54.02	DR. E	27,552	0	27,552	217,600	168	5.00
6.00	59.00	DR. F	32,446	0	32,446	217,600	168	6.00
7.00	60.00	DR. G	125,000	20,833	104,167	208,000	559	7.00
8.00	54.01	DR. H	659,953	415,619	244,334	217,600	1,220	8.00
9.00	65.00	DR. I	11,700	0	11,700	159,800	90	9.00
10.00	69.00	DR. J	206,875	206,875	0	0	0	10.00
11.00	70.00	DR. K	6,000	6,000	0	0	0	11.00
12.00	91.00	DR. L	2,619,031	2,592,777	26,254	159,800	190	12.00
13.00	5.06	DR. M	31,460	0	31,460	159,800	210	13.00
200.00			7,465,505	6,882,622	582,883		3,265	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	DR. A	0	0	0	0	0	1.00
2.00	31.00	DR. B	31,345	1,567	0	0	0	2.00
3.00	35.00	DR. C	18,592	930	0	0	0	3.00
4.00	50.00	DR. D	879	44	0	0	0	4.00
5.00	54.02	DR. E	17,575	879	0	0	0	5.00
6.00	59.00	DR. F	17,575	879	0	0	0	6.00
7.00	60.00	DR. G	55,900	2,795	0	0	0	7.00
8.00	54.01	DR. H	127,631	6,382	0	0	0	8.00
9.00	65.00	DR. I	6,914	346	0	0	0	9.00
10.00	69.00	DR. J	0	0	0	0	0	10.00
11.00	70.00	DR. K	0	0	0	0	0	11.00
12.00	91.00	DR. L	14,597	730	0	0	0	12.00
13.00	5.06	DR. M	16,134	807	0	0	0	13.00
200.00			307,142	15,359	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	DR. A	0	0	0	2,658,025	1.00
2.00	31.00	DR. B	0	31,345	21,760	21,760	2.00
3.00	35.00	DR. C	0	18,592	29,808	586,970	3.00
4.00	50.00	DR. D	0	879	2,586	427,917	4.00
5.00	54.02	DR. E	0	17,575	9,977	9,977	5.00
6.00	59.00	DR. F	0	17,575	14,871	14,871	6.00
7.00	60.00	DR. G	0	55,900	48,267	69,100	7.00
8.00	54.01	DR. H	0	127,631	116,703	532,322	8.00
9.00	65.00	DR. I	0	6,914	4,786	4,786	9.00
10.00	69.00	DR. J	0	0	0	206,875	10.00
11.00	70.00	DR. K	0	0	0	6,000	11.00
12.00	91.00	DR. L	0	14,597	11,657	2,604,434	12.00
13.00	5.06	DR. M	0	16,134	15,326	15,326	13.00
200.00			0	307,142	275,741	7,158,363	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140164

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

Worksheet B  
Part I  
Date/Time Prepared:  
8/26/2014 5:56 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.02	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	4,602,799	4,602,799			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	10,558,351		10,558,351		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	23,407,101	17,447	9,994	23,434,542	4.00
5.02 00551	DATA PROCESSING	5,326,224	22,936	0	0	5.02
5.03 00560	PURCHASING RECEIVING AND STORES	102,660	49,612	32,773	0	5.03
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	4,387,002	46,884	2,618	278,163	5.05
5.06 00590	OTHER ADMINISTRATIVE AND GENERAL	18,110,577	908,336	113,033	1,129,235	5.06
6.00 00600	MAINTENANCE & REPAIRS	2,447,529	625,010	12,459	282,420	6.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,253,881	15,697	0	17,579	8.00
9.00 00900	HOUSEKEEPING	1,594,008	34,075	10,383	402,782	9.00
10.00 01000	DIETARY	596,852	70,542	45,673	139,489	10.00
11.00 01100	CAFETERIA	957,184	79,194	0	438,204	11.00
13.00 01300	NURSING ADMINISTRATION	1,098,952	77,091	251,153	433,241	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,272,217	48,136	144,091	352,069	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	533,604	0	2,295	220,422	16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	998,882	0	0	413,068	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	917,769	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	16,842,493	1,032,538	490,749	5,337,132	30.00
31.00 03100	INTENSIVE CARE UNIT	3,539,745	112,563	192,621	1,196,786	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	1,108,413	29,822	135,264	432,968	35.00
43.00 04300	NURSERY	207,982	14,670	9,085	19,397	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	9,176,110	326,196	2,025,907	2,032,628	50.00
50.01 03020	SAME DAY SURGERY	0	0	0	0	50.01
51.00 05100	RECOVERY ROOM	696,657	61,586	0	273,803	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,994,068	148,195	123,036	1,491,529	52.00
53.00 05300	ANESTHESIOLOGY	492,341	6,725	142,716	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,915,432	139,865	1,939,744	1,166,513	54.00
54.01 03480	ONCOLOGY	1,910,263	106,624	936,281	393,892	54.01
54.02 03440	MAMMOGRAPHY	1,104,198	0	358,569	263,295	54.02
56.00 05600	RADIOISOTOPE	1,342,407	28,843	151,258	138,105	56.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	211,224	20,240	831,130	83,394	58.00
59.00 05900	CARDIAC CATHETERIZATION	8,437,160	168,740	1,042,920	1,101,707	59.00
60.00 06000	LABORATORY	6,773,392	90,830	324,952	969,029	60.00
65.00 06500	RESPIRATORY THERAPY	1,586,409	20,095	91,700	513,672	65.00
66.00 06600	PHYSICAL THERAPY	2,721,705	0	34,534	794,843	66.00
69.00 06900	ELECTROCARDIOLOGY	7,023,315	35,985	553,511	462,043	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	233,645	12,921	60,355	40,234	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,544,967	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	13,947,988	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	8,473,368	30,368	26,465	1,047,332	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	1,275,505	0	12,338	168,643	88.00
91.00 09100	EMERGENCY	4,289,766	145,772	449,130	1,400,925	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	188,014,145	4,527,538	10,556,737	23,434,542	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	105,079	12,038	1,614	0	192.00
192.01 19201	FAMILY PRACTICE	0	2,680	0	0	192.01
192.02 19202	REFERENCE LAB	0	0	0	0	192.02
192.03 19203	UNUSED SPACE	0	60,543	0	0	192.03
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	188,119,224	4,602,799	10,558,351	23,434,542	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140164

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

Worksheet B Part I Date/Time Prepared: 8/26/2014 5:56 pm

Cost Center Description			PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.03	5.05	5A.05	5.06	6.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00551	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	213,468					5.03
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	549	4,828,907				5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	0	0	20,642,046	20,642,046		5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	3,412,894	420,649	3,833,543	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	8	0	1,287,165	158,647	20,520	8.00
9.00	00900	HOUSEKEEPING	39	0	2,069,710	255,098	44,544	9.00
10.00	01000	DIETARY	31	0	932,171	114,893	92,215	10.00
11.00	01100	CAFETERIA	96	0	1,474,678	181,758	103,524	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	2,008,235	247,521	100,776	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,273	0	1,829,155	225,449	62,924	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	881,381	108,633	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1,411,950	174,027	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	1,020,091	125,729	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	29,485	275,910	25,042,894	3,086,596	1,349,763	30.00
31.00	03100	INTENSIVE CARE UNIT	10,031	36,123	5,281,144	650,917	147,145	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	33	43,144	1,806,489	222,655	38,984	35.00
43.00	04300	NURSERY	3,012	12,937	278,452	34,320	19,177	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	105,481	716,736	14,780,976	1,821,800	426,413	50.00
50.01	03020	SAME DAY SURGERY	0	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	628	67,748	1,100,422	135,630	80,507	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,191	51,716	6,046,801	745,286	193,725	52.00
53.00	05300	ANESTHESIOLOGY	11,397	101,247	771,480	95,087	8,791	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,628	549,096	7,917,237	975,823	182,835	54.00
54.01	03480	ONCOLOGY	8	201,277	3,679,090	453,459	139,382	54.01
54.02	03440	MAMMOGRAPHY	281	56,276	1,981,578	244,235	0	54.02
56.00	05600	RADIOISOTOPE	226	69,512	1,758,774	216,774	37,704	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	91	100,550	1,252,314	154,351	26,458	58.00
59.00	05900	CARDIAC CATHETERIZATION	22,483	274,762	11,292,208	1,391,799	220,582	59.00
60.00	06000	LABORATORY	3,129	557,508	8,957,591	1,104,050	118,736	60.00
65.00	06500	RESPIRATORY THERAPY	1,912	70,732	2,534,640	312,402	26,269	65.00
66.00	06600	PHYSICAL THERAPY	560	82,378	3,923,932	483,636	0	66.00
69.00	06900	ELECTROCARDIOLOGY	819	305,188	8,443,391	1,040,673	47,041	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	20	8,222	372,451	45,906	16,890	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	753,695	11,298,662	1,392,594	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	13,947,988	1,719,131	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	205	266,649	9,946,709	1,225,962	39,698	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	166	9,411	1,704,814	210,123	0	88.00
91.00	09100	EMERGENCY	8,686	218,090	6,813,650	839,803	190,557	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	213,468	4,828,907	187,903,163	20,615,416	3,735,160	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	152,838	18,838	15,736	192.00
192.01	19201	FAMILY PRACTICE	0	0	2,680	330	3,504	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
192.03	19203	UNUSED SPACE	0	0	60,543	7,462	79,143	192.03
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	213,468	4,828,907	188,119,224	20,642,046	3,833,543	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet B Part I Date/Time Prepared: 8/26/2014 5:56 pm
---	--	----------------------	---	---

Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION		
		8.00	9.00	10.00	11.00	13.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.02	00551	DATA PROCESSING					5.02	
5.03	00560	PURCHASING RECEIVING AND STORES					5.03	
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05	
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL					5.06	
6.00	00600	MAINTENANCE & REPAIRS					6.00	
8.00	00800	LAUNDRY & LINEN SERVICE	1,466,332				8.00	
9.00	00900	HOUSEKEEPING	0	2,369,352			9.00	
10.00	01000	DIETARY	0	57,978	1,197,257		10.00	
11.00	01100	CAFETERIA	0	65,089	0	1,825,049	11.00	
13.00	01300	NURSING ADMINISTRATION	0	63,361	0	23,022	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	39,562	0	60,695	14.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	35,580	16.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00	
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	37,673	22.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	1,237,489	848,633	1,010,408	487,656	1,041,576	30.00
31.00	03100	INTENSIVE CARE UNIT	160,077	92,515	130,702	87,904	189,499	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	68,766	24,510	56,147	31,394	65,995	35.00
43.00	04300	NURSERY	0	12,057	0	2,093	2,761	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	268,098	0	171,622	368,315	50.00
50.01	03020	SAME DAY SURGERY	0	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0	50,617	0	18,837	38,266	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	121,801	0	125,577	266,080	52.00
53.00	05300	ANESTHESIOLOGY	0	5,527	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	114,954	0	98,368	0	54.00
54.01	03480	ONCOLOGY	0	87,634	0	31,394	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	31,394	0	54.02
56.00	05600	RADIOISOTOPE	0	23,706	0	8,372	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	16,635	0	6,279	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	138,686	0	85,811	182,305	59.00
60.00	06000	LABORATORY	0	74,653	0	108,833	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	16,516	0	48,138	13,534	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	64,881	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	29,576	0	43,952	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	10,619	0	4,186	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	24,959	0	56,510	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	27,208	0	88.00
91.00	09100	EMERGENCY	0	119,809	0	127,670	274,584	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,466,332	2,307,495	1,197,257	1,825,049	2,442,915	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	9,894	0	0	0	192.00
192.01	19201	FAMILY PRACTICE	0	2,203	0	0	0	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
192.03	19203	UNUSED SPACE	0	49,760	0	0	0	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,466,332	2,369,352	1,197,257	1,825,049	2,442,915	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140164

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

Worksheet B  
Part I  
Date/Time Prepared:  
8/26/2014 5:56 pm

Cost Center Description	INTERNS & RESIDENTS					
	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS	
	14.00	16.00	19.00	21.00	22.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02 00551 DATA PROCESSING						5.02
5.03 00560 PURCHASING RECEIVING AND STORES						5.03
5.05 00580 CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06 00590 OTHER ADMINISTRATIVE AND GENERAL						5.06
6.00 00600 MAINTENANCE & REPAIRS						6.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	2,217,785					14.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	1,025,594				16.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	1,585,977		21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	1,183,493	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	2,120	58,603	0	223,168	166,533	30.00
31.00 03100 INTENSIVE CARE UNIT	4,131	7,672	0	5,112	3,815	31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	9,164	0	0	0	35.00
43.00 04300 NURSERY	17	2,748	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	1,262,999	152,232	0	62,845	46,896	50.00
50.01 03020 SAME DAY SURGERY	0	0	0	0	0	50.01
51.00 05100 RECOVERY ROOM	25	14,390	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	523	10,984	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	15,687	21,505	0	2,556	1,907	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	55,518	116,626	0	0	0	54.00
54.01 03480 ONCOLOGY	541	42,751	0	0	0	54.01
54.02 03440 MAMMOGRAPHY	10,189	11,953	0	0	0	54.02
56.00 05600 RADIOISOTOPE	0	14,764	0	0	0	56.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	10	21,356	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	847,019	58,359	0	0	0	59.00
60.00 06000 LABORATORY	4,333	118,413	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	9,083	15,023	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	16	17,497	0	52,206	38,957	66.00
69.00 06900 ELECTROCARDIOLOGY	956	64,821	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	2,340	1,746	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,159	160,031	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	56,635	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	431	1,999	0	161,026	120,161	88.00
91.00 09100 EMERGENCY	688	46,322	0	87,095	64,992	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	2,217,785	1,025,594	0	594,008	443,261	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 19201 FAMILY PRACTICE	0	0	0	991,969	740,232	192.01
192.02 19202 REFERENCE LAB	0	0	0	0	0	192.02
192.03 19203 UNUSED SPACE	0	0	0	0	0	192.03
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)	2,217,785	1,025,594	0	1,585,977	1,183,493	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140164

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

Worksheet B  
Part I  
Date/Time Prepared:  
8/26/2014 5:56 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.02	00551				5.02
5.03	00560				5.03
5.05	00580				5.05
5.06	00590				5.06
6.00	00600				6.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
16.00	01600				16.00
19.00	01900				19.00
21.00	02100				21.00
22.00	02200				22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	34,555,439	-389,701	34,165,738	30.00
31.00	03100	6,760,633	-8,927	6,751,706	31.00
35.00	02060	2,324,104	0	2,324,104	35.00
43.00	04300	351,625	0	351,625	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	19,362,196	-109,741	19,252,455	50.00
50.01	03020	0	0	0	50.01
51.00	05100	1,438,694	0	1,438,694	51.00
52.00	05200	7,510,777	0	7,510,777	52.00
53.00	05300	922,540	-4,463	918,077	53.00
54.00	05400	9,461,361	0	9,461,361	54.00
54.01	03480	4,434,251	0	4,434,251	54.01
54.02	03440	2,279,349	0	2,279,349	54.02
56.00	05600	2,060,094	0	2,060,094	56.00
58.00	05800	1,477,403	0	1,477,403	58.00
59.00	05900	14,216,769	0	14,216,769	59.00
60.00	06000	10,486,609	0	10,486,609	60.00
65.00	06500	2,975,605	0	2,975,605	65.00
66.00	06600	4,581,125	-91,163	4,489,962	66.00
69.00	06900	9,670,410	0	9,670,410	69.00
70.00	07000	454,138	0	454,138	70.00
71.00	07100	12,852,446	0	12,852,446	71.00
72.00	07200	15,667,119	0	15,667,119	72.00
73.00	07300	11,350,473	0	11,350,473	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	2,225,762	-281,187	1,944,575	88.00
91.00	09100	8,565,170	-152,087	8,413,083	91.00
92.00	09200		0		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300				113.00
118.00		185,984,092	-1,037,269	184,946,823	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	0	0	0	190.00
192.00	19200	197,306	0	197,306	192.00
192.01	19201	1,740,918	-1,732,201	8,717	192.01
192.02	19202	0	0	0	192.02
192.03	19203	196,908	0	196,908	192.03
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		188,119,224	-2,769,470	185,349,754	202.00

COST ALLOCATION STATISTICS

Provider CCN: 140164

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

Worksheet Non-CMS W  
Date/Time Prepared:  
8/26/2014 5:56 pm

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES	4.00
5.02	DATA PROCESSING	5	NUMBER OF PCS	5.02
5.03	PURCHASING RECEIVING AND STORES	6	PURCHASING SUPPLIES	5.03
5.05	CASHIERING/ACCOUNTS RECEIVABLE	7	GROSS REVENUE	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	-5	ACCUM. COST	5.06
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
8.00	LAUNDRY & LINEN SERVICE	8	PATIENT DAYS	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	9	MEALS SERVED	10.00
11.00	CAFETERIA	10	NUMBER OF FTES	11.00
13.00	NURSING ADMINISTRATION	11	DIRECT NURS. HRS.	13.00
14.00	CENTRAL SERVICES & SUPPLY	12	NUMBER HOUSED	14.00
16.00	MEDICAL RECORDS & LIBRARY	7	GROSS REVENUE	16.00
19.00	NONPHYSICIAN ANESTHETISTS	13	DIRECT NURS. HRS.	19.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	14	ASSIGNED TIME	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	14	ASSIGNED TIME	22.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140164

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

Worksheet B Part II Date/Time Prepared: 8/26/2014 5:56 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	17,447	9,994	27,441	27,441 4.00
5.02 00551	DATA PROCESSING	0	22,936	0	22,936	0 5.02
5.03 00560	PURCHASING RECEIVING AND STORES	0	49,612	32,773	82,385	0 5.03
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	46,884	2,618	49,502	326 5.05
5.06 00590	OTHER ADMINISTRATIVE AND GENERAL	0	908,336	113,033	1,021,369	1,322 5.06
6.00 00600	MAINTENANCE & REPAIRS	0	625,010	12,459	637,469	331 6.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	15,697	0	15,697	21 8.00
9.00 00900	HOUSEKEEPING	0	34,075	10,383	44,458	471 9.00
10.00 01000	DIETARY	0	70,542	45,673	116,215	163 10.00
11.00 01100	CAFETERIA	0	79,194	0	79,194	513 11.00
13.00 01300	NURSING ADMINISTRATION	0	77,091	251,153	328,244	507 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	48,136	144,091	192,227	412 14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	2,295	2,295	258 16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	483 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0 22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	1,032,538	490,749	1,523,287	6,259 30.00
31.00 03100	INTENSIVE CARE UNIT	0	112,563	192,621	305,184	1,401 31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	0	29,822	135,264	165,086	507 35.00
43.00 04300	NURSERY	0	14,670	9,085	23,755	23 43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	326,196	2,025,907	2,352,103	2,379 50.00
50.01 03020	SAME DAY SURGERY	0	0	0	0	0 50.01
51.00 05100	RECOVERY ROOM	0	61,586	0	61,586	320 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	148,195	123,036	271,231	1,746 52.00
53.00 05300	ANESTHESIOLOGY	0	6,725	142,716	149,441	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	139,865	1,939,744	2,079,609	1,365 54.00
54.01 03480	ONCOLOGY	0	106,624	936,281	1,042,905	461 54.01
54.02 03440	MAMMOGRAPHY	0	0	358,569	358,569	308 54.02
56.00 05600	RADIOISOTOPE	0	28,843	151,258	180,101	162 56.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	20,240	831,130	851,370	98 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	168,740	1,042,920	1,211,660	1,289 59.00
60.00 06000	LABORATORY	0	90,830	324,952	415,782	1,134 60.00
65.00 06500	RESPIRATORY THERAPY	0	20,095	91,700	111,795	601 65.00
66.00 06600	PHYSICAL THERAPY	0	0	34,534	34,534	930 66.00
69.00 06900	ELECTROCARDIOLOGY	0	35,985	553,511	589,496	541 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	12,921	60,355	73,276	47 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	30,368	26,465	56,833	1,226 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	12,338	12,338	197 88.00
91.00 09100	EMERGENCY	0	145,772	449,130	594,902	1,640 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	0 92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	4,527,538	10,556,737	15,084,275	27,441 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	12,038	1,614	13,652	0 192.00
192.01 19201	FAMILY PRACTICE	0	2,680	0	2,680	0 192.01
192.02 19202	REFERENCE LAB	0	0	0	0	0 192.02
192.03 19203	UNUSED SPACE	0	60,543	0	60,543	0 192.03
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	0	4,602,799	10,558,351	15,161,150	27,441 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140164

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

Worksheet B  
Part II  
Date/Time Prepared:  
8/26/2014 5:56 pm

Cost Center Description		DATA PROCESSING	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
		5.02	5.03	5.05	5.06	6.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.02	00551	22,936					5.02
5.03	00560	122	82,507				5.03
5.05	00580	487	212	50,527			5.05
5.06	00590	1,633	0	0	1,024,324		5.06
6.00	00600	195	0	0	20,873	658,868	6.00
8.00	00800	0	3	0	7,872	3,527	8.00
9.00	00900	122	15	0	12,658	7,656	9.00
10.00	01000	341	12	0	5,701	15,849	10.00
11.00	01100	0	37	0	9,019	17,793	11.00
13.00	01300	634	0	0	12,282	17,320	13.00
14.00	01400	49	492	0	11,187	10,815	14.00
16.00	01600	536	0	0	5,391	0	16.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	0	0	0	8,635	0	21.00
22.00	02200	439	0	0	6,239	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	4,436	11,396	2,903	153,199	231,982	30.00
31.00	03100	829	3,877	380	32,299	25,290	31.00
35.00	02060	244	13	454	11,048	6,700	35.00
43.00	04300	49	1,164	136	1,703	3,296	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	1,706	40,773	7,540	90,400	73,287	50.00
50.01	03020	0	0	0	0	0	50.01
51.00	05100	0	243	713	6,730	13,837	51.00
52.00	05200	999	2,006	544	36,982	33,295	52.00
53.00	05300	73	4,405	1,065	4,718	1,511	53.00
54.00	05400	853	2,948	5,777	48,422	31,424	54.00
54.01	03480	561	3	2,118	22,501	23,955	54.01
54.02	03440	853	108	592	12,119	0	54.02
56.00	05600	122	87	731	10,757	6,480	56.00
58.00	05800	24	35	1,058	7,659	4,547	58.00
59.00	05900	1,048	8,689	2,891	69,063	37,911	59.00
60.00	06000	1,024	1,209	5,865	54,785	20,407	60.00
65.00	06500	1,072	739	744	15,502	4,515	65.00
66.00	06600	1,243	216	867	23,999	0	66.00
69.00	06900	268	317	3,211	51,640	8,085	69.00
70.00	07000	73	8	86	2,278	2,903	70.00
71.00	07100	0	0	7,654	69,103	0	71.00
72.00	07200	0	0	0	85,306	0	72.00
73.00	07300	439	79	2,805	60,834	6,823	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	1,024	64	99	10,427	0	88.00
91.00	09100	1,292	3,357	2,294	41,672	32,751	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		22,790	82,507	50,527	1,023,003	641,959	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	146	0	0	935	2,705	192.00
192.01	19201	0	0	0	16	602	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	0	0	0	370	13,602	192.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		22,936	82,507	50,527	1,024,324	658,868	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet B Part II Date/Time Prepared: 8/26/2014 5:56 pm				
Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION		
		8.00	9.00	10.00	11.00	13.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.02	00551	DATA PROCESSING					5.02	
5.03	00560	PURCHASING RECEIVING AND STORES					5.03	
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05	
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL					5.06	
6.00	00600	MAINTENANCE & REPAIRS					6.00	
8.00	00800	LAUNDRY & LINEN SERVICE	27,120				8.00	
9.00	00900	HOUSEKEEPING	0	65,380			9.00	
10.00	01000	DIETARY	0	1,600	139,881		10.00	
11.00	01100	CAFETERIA	0	1,796	0	108,352	11.00	
13.00	01300	NURSING ADMINISTRATION	0	1,748	0	1,367	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,092	0	3,603	14.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	2,112	16.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00	
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	2,237	22.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	22,887	23,416	118,050	28,952	154,388	30.00
31.00	03100	INTENSIVE CARE UNIT	2,961	2,553	15,271	5,219	28,089	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,272	676	6,560	1,864	9,782	35.00
43.00	04300	NURSERY	0	333	0	124	409	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	7,398	0	10,189	54,594	50.00
50.01	03020	SAME DAY SURGERY	0	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0	1,397	0	1,118	5,672	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,361	0	7,455	39,440	52.00
53.00	05300	ANESTHESIOLOGY	0	153	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,172	0	5,840	0	54.00
54.01	03480	ONCOLOGY	0	2,418	0	1,864	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	1,864	0	54.02
56.00	05600	RADIOISOTOPE	0	654	0	497	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	459	0	373	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,827	0	5,095	27,022	59.00
60.00	06000	LABORATORY	0	2,060	0	6,461	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	456	0	2,858	2,006	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,852	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	816	0	2,609	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	293	0	249	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	689	0	3,355	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,615	0	88.00
91.00	09100	EMERGENCY	0	3,306	0	7,580	40,700	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,120	63,673	139,881	108,352	362,102	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	273	0	0	0	192.00
192.01	19201	FAMILY PRACTICE	0	61	0	0	0	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
192.03	19203	UNUSED SPACE	0	1,373	0	0	0	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	27,120	65,380	139,881	108,352	362,102	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140164

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

Worksheet B  
Part II  
Date/Time Prepared:  
8/26/2014 5:56 pm

Cost Center Description	INTERNS & RESIDENTS					
	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS	
	14.00	16.00	19.00	21.00	22.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.02 00551	DATA PROCESSING					5.02
5.03 00560	PURCHASING RECEIVING AND STORES					5.03
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06 00590	OTHER ADMINISTRATIVE AND GENERAL					5.06
6.00 00600	MAINTENANCE & REPAIRS					6.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	219,877				14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	10,592			16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0		19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0		9,118	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0			22.00
						8,915
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	210	588			30.00
31.00 03100	INTENSIVE CARE UNIT	410	77			31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	0	92			35.00
43.00 04300	NURSERY	2	28			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	125,212	1,528			50.00
50.01 03020	SAME DAY SURGERY	0	0			50.01
51.00 05100	RECOVERY ROOM	2	144			51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	52	110			52.00
53.00 05300	ANESTHESIOLOGY	1,555	216			53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	5,504	1,171			54.00
54.01 03480	ONCOLOGY	54	429			54.01
54.02 03440	MAMMOGRAPHY	1,010	120			54.02
56.00 05600	RADIOISOTOPE	0	148			56.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	1	214			58.00
59.00 05900	CARDIAC CATHETERIZATION	83,979	586			59.00
60.00 06000	LABORATORY	430	1,189			60.00
65.00 06500	RESPIRATORY THERAPY	901	151			65.00
66.00 06600	PHYSICAL THERAPY	2	176			66.00
69.00 06900	ELECTROCARDIOLOGY	95	651			69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	232	18			70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	115	1,902			71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	569			73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	43	20			88.00
91.00 09100	EMERGENCY	68	465			91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	219,877	10,592	0	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0			192.00
192.01 19201	FAMILY PRACTICE	0	0			192.01
192.02 19202	REFERENCE LAB	0	0			192.02
192.03 19203	UNUSED SPACE	0	0			192.03
200.00	Cross Foot Adjustments			0	9,118	8,915
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118-201)	219,877	10,592	0	9,118	8,915

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140164

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

Worksheet B  
Part II  
Date/Time Prepared:  
8/26/2014 5:56 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.02	00551				5.02
5.03	00560				5.03
5.05	00580				5.05
5.06	00590				5.06
6.00	00600				6.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
16.00	01600				16.00
19.00	01900				19.00
21.00	02100				21.00
22.00	02200				22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	2,281,953	0	2,281,953	30.00
31.00	03100	423,840	0	423,840	31.00
35.00	02060	204,298	0	204,298	35.00
43.00	04300	31,022	0	31,022	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	2,767,109	0	2,767,109	50.00
50.01	03020	0	0	0	50.01
51.00	05100	91,762	0	91,762	51.00
52.00	05200	397,221	0	397,221	52.00
53.00	05300	163,137	0	163,137	53.00
54.00	05400	2,186,085	0	2,186,085	54.00
54.01	03480	1,097,269	0	1,097,269	54.01
54.02	03440	375,543	0	375,543	54.02
56.00	05600	199,739	0	199,739	56.00
58.00	05800	865,838	0	865,838	58.00
59.00	05900	1,453,060	0	1,453,060	59.00
60.00	06000	510,346	0	510,346	60.00
65.00	06500	141,340	0	141,340	65.00
66.00	06600	65,819	0	65,819	66.00
69.00	06900	657,729	0	657,729	69.00
70.00	07000	79,463	0	79,463	70.00
71.00	07100	78,774	0	78,774	71.00
72.00	07200	85,306	0	85,306	72.00
73.00	07300	133,652	0	133,652	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	25,827	0	25,827	88.00
91.00	09100	730,027	0	730,027	91.00
92.00	09200		0		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300				113.00
118.00		15,046,159	0	15,046,159	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	0	0	0	190.00
192.00	19200	17,711	0	17,711	192.00
192.01	19201	3,359	0	3,359	192.01
192.02	19202	0	0	0	192.02
192.03	19203	75,888	0	75,888	192.03
200.00		18,033	0	18,033	200.00
201.00		0	0	0	201.00
202.00		15,161,150	0	15,161,150	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140164

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

Worksheet B-1

Date/Time Prepared:  
8/26/2014 5:56 pm

Cost Center Description	CAPITAL RELATED COSTS					EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (NUMBER OF PCS)	PURCHASING RECEIVING AND STORES (PURCHASING SUPPLIES)
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)						
	1.00	2.00	4.00	5.02	5.03			
<b>GENERAL SERVICE COST CENTERS</b>								
1.00 00100	CAP REL COSTS-BLDG & FIXT	286,768						1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		5,166,943					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,087	4,891	56,669,484				4.00
5.02 00551	DATA PROCESSING	1,429	0	0	941			5.02
5.03 00560	PURCHASING RECEIVING AND STORES	3,091	16,038	0	5	10,565,308		5.03
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	2,921	1,281	672,655	20	27,178		5.05
5.06 00590	OTHER ADMINISTRATIVE AND GENERAL	56,592	55,315	2,730,722	67	0		5.06
6.00 00600	MAINTENANCE & REPAIRS	38,940	6,097	682,949	8	18		6.00
8.00 00800	LAUNDRY & LINEN SERVICE	978	0	42,510	0	420		8.00
9.00 00900	HOUSEKEEPING	2,123	5,081	974,009	5	1,916		9.00
10.00 01000	DIETARY	4,395	22,351	337,312	14	1,518		10.00
11.00 01100	CAFETERIA	4,934	0	1,059,667	0	4,769		11.00
13.00 01300	NURSING ADMINISTRATION	4,803	122,907	1,047,665	26	0		13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	2,999	70,514	851,375	2	62,992		14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	1,123	533,025	22	0		16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0		19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	998,882	0	0		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	18	0		22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00 03000	ADULTS & PEDIATRICS	64,330	240,158	12,906,257	182	1,459,290		30.00
31.00 03100	INTENSIVE CARE UNIT	7,013	94,263	2,894,074	34	496,453		31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	1,858	66,194	1,047,005	10	1,643		35.00
43.00 04300	NURSERY	914	4,446	46,906	2	149,081		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00 05000	OPERATING ROOM	20,323	991,419	4,915,309	70	5,220,745		50.00
50.01 03020	SAME DAY SURGERY	0	0	0	0	0		50.01
51.00 05100	RECOVERY ROOM	3,837	0	662,112	0	31,062		51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	9,233	60,210	3,606,821	41	256,892		52.00
53.00 05300	ANESTHESIOLOGY	419	69,841	0	3	564,071		53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	8,714	949,253	2,820,867	35	377,523		54.00
54.01 03480	ONCOLOGY	6,643	458,188	952,511	23	408		54.01
54.02 03440	MAMMOGRAPHY	0	175,473	636,700	35	13,888		54.02
56.00 05600	RADIOISOTOPE	1,797	74,021	333,965	5	11,184		56.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	1,261	406,730	201,663	1	4,518		58.00
59.00 05900	CARDIAC CATHETERIZATION	10,513	510,374	2,664,152	43	1,112,725		59.00
60.00 06000	LABORATORY	5,659	159,022	2,343,309	42	154,861		60.00
65.00 06500	RESPIRATORY THERAPY	1,252	44,875	1,242,163	44	94,626		65.00
66.00 06600	PHYSICAL THERAPY	0	16,900	1,922,092	51	27,698		66.00
69.00 06900	ELECTROCARDIOLOGY	2,242	270,872	1,117,314	11	40,537		69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	805	29,536	97,295	3	1,003		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	1,892	12,951	2,532,662	18	10,148		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00 08800	RURAL HEALTH CLINIC	0	6,038	407,813	42	8,237		88.00
91.00 09100	EMERGENCY	9,082	219,791	3,387,723	53	429,904		91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)							92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00 11300	INTEREST EXPENSE							113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	282,079	5,166,153	56,669,484	935	10,565,308		118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0		190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	750	790	0	6	0		192.00
192.01 19201	FAMILY PRACTICE	167	0	0	0	0		192.01
192.02 19202	REFERENCE LAB	0	0	0	0	0		192.02
192.03 19203	UNUSED SPACE	3,772	0	0	0	0		192.03
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers							201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	4,602,799	10,558,351	23,434,542	5,349,160	213,468		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	16.050602	2.043443	0.413530	5,684.548353	0.020205		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			27,441	22,936	82,507		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000484	24.374070	0.007809		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140164

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

Worksheet B-1  
Date/Time Prepared: 8/26/2014 5:56 pm

Cost Center Description		CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	
		5.05	5A.06	5.06	6.00	8.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.02	00551						5.02
5.03	00560						5.03
5.05	00580	686,465,198					5.05
5.06	00590	0	-20,642,046	167,477,178			5.06
6.00	00600	0	0	3,412,894	182,708		6.00
8.00	00800	0	0	1,287,165	978	35,056	8.00
9.00	00900	0	0	2,069,710	2,123	0	9.00
10.00	01000	0	0	932,171	4,395	0	10.00
11.00	01100	0	0	1,474,678	4,934	0	11.00
13.00	01300	0	0	2,008,235	4,803	0	13.00
14.00	01400	0	0	1,829,155	2,999	0	14.00
16.00	01600	0	0	881,381	0	0	16.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	0	0	1,411,950	0	0	21.00
22.00	02200	0	0	1,020,091	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	39,225,252	0	25,042,894	64,330	29,585	30.00
31.00	03100	5,135,439	0	5,281,144	7,013	3,827	31.00
35.00	02060	6,133,699	0	1,806,489	1,858	1,644	35.00
43.00	04300	1,839,264	0	278,452	914	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	101,895,897	0	14,780,976	20,323	0	50.00
50.01	03020	0	0	0	0	0	50.01
51.00	05100	9,631,553	0	1,100,422	3,837	0	51.00
52.00	05200	7,352,290	0	6,046,801	9,233	0	52.00
53.00	05300	14,393,963	0	771,480	419	0	53.00
54.00	05400	78,063,076	0	7,917,237	8,714	0	54.00
54.01	03480	28,614,872	0	3,679,090	6,643	0	54.01
54.02	03440	8,000,607	0	1,981,578	0	0	54.02
56.00	05600	9,882,248	0	1,758,774	1,797	0	56.00
58.00	05800	14,294,824	0	1,252,314	1,261	0	58.00
59.00	05900	39,062,010	0	11,292,208	10,513	0	59.00
60.00	06000	79,259,046	0	8,957,591	5,659	0	60.00
65.00	06500	10,055,755	0	2,534,640	1,252	0	65.00
66.00	06600	11,711,351	0	3,923,932	0	0	66.00
69.00	06900	43,387,521	0	8,443,391	2,242	0	69.00
70.00	07000	1,168,824	0	372,451	805	0	70.00
71.00	07100	107,106,059	0	11,298,662	0	0	71.00
72.00	07200	0	0	13,947,988	0	0	72.00
73.00	07300	37,908,585	0	9,946,709	1,892	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	1,337,984	0	1,704,814	0	0	88.00
91.00	09100	31,005,079	0	6,813,650	9,082	0	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		686,465,198	-20,642,046	167,261,117	178,019	35,056	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	152,838	750	0	192.00
192.01	19201	0	0	2,680	167	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	0	0	60,543	3,772	0	192.03
200.00							200.00
201.00							201.00
202.00		4,828,907		20,642,046	3,833,543	1,466,332	202.00
203.00		0.007034		0.123253	20.981802	41.828275	203.00
204.00		50,527		1,024,324	658,868	27,120	204.00
205.00		0.000074		0.006116	3.606126	0.773619	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140164

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

Worksheet B-1

Date/Time Prepared:  
8/26/2014 5:56 pm

Cost Center Description		HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER OF FTES)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (NUMBER HOUSED)	
		9.00	10.00	11.00	13.00	14.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.02	00551						5.02
5.03	00560						5.03
5.05	00580						5.05
5.06	00590						5.06
6.00	00600						6.00
8.00	00800						8.00
9.00	00900	179,607					9.00
10.00	01000	4,395	105,168				10.00
11.00	01100	4,934	0	872			11.00
13.00	01300	4,803	0	11	1,137,890		13.00
14.00	01400	2,999	0	29	0	24,491,604	14.00
16.00	01600	0	0	17	0	0	16.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	18	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	64,330	88,755	233	485,158	23,410	30.00
31.00	03100	7,013	11,481	42	88,267	45,617	31.00
35.00	02060	1,858	4,932	15	30,740	0	35.00
43.00	04300	914	0	1	1,286	186	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	20,323	0	82	171,558	13,947,643	50.00
50.01	03020	0	0	0	0	0	50.01
51.00	05100	3,837	0	9	17,824	275	51.00
52.00	05200	9,233	0	60	123,938	5,781	52.00
53.00	05300	419	0	0	0	173,241	53.00
54.00	05400	8,714	0	47	0	613,102	54.00
54.01	03480	6,643	0	15	0	5,969	54.01
54.02	03440	0	0	15	0	112,525	54.02
56.00	05600	1,797	0	4	0	0	56.00
58.00	05800	1,261	0	3	0	112	58.00
59.00	05900	10,513	0	41	84,916	9,353,844	59.00
60.00	06000	5,659	0	52	0	47,855	60.00
65.00	06500	1,252	0	23	6,304	100,301	65.00
66.00	06600	0	0	31	0	180	66.00
69.00	06900	2,242	0	21	0	10,556	69.00
70.00	07000	805	0	2	0	25,846	70.00
71.00	07100	0	0	0	0	12,799	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	1,892	0	27	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	13	0	4,762	88.00
91.00	09100	9,082	0	61	127,899	7,600	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		174,918	105,168	872	1,137,890	24,491,604	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	750	0	0	0	0	192.00
192.01	19201	167	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	3,772	0	0	0	0	192.03
200.00							200.00
201.00							201.00
202.00		2,369,352	1,197,257	1,825,049	2,442,915	2,217,785	202.00
203.00		13.191869	11.384233	2,092.946101	2.146882	0.090553	203.00
204.00		65,380	139,881	108,352	362,102	219,877	204.00
205.00		0.364017	1.330072	124.256881	0.318222	0.008978	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140164

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

Worksheet B-1

Date/Time Prepared:  
8/26/2014 5:56 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	NONPHYSICIAN ANESTHETISTS (DIRECT NURS. HRS.)	INTERNS & RESIDENTS			
			SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)		
	16.00	19.00	21.00	22.00		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.02 00551	DATA PROCESSING					5.02
5.03 00560	PURCHASING RECEIVING AND STORES					5.03
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06 00590	OTHER ADMINISTRATIVE AND GENERAL					5.06
6.00 00600	MAINTENANCE & REPAIRS					6.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	686,465,198				16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0			19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0		49,640		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0			49,640	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	39,225,252		6,985	6,985	30.00
31.00 03100	INTENSIVE CARE UNIT	5,135,439		160	160	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	6,133,699		0	0	35.00
43.00 04300	NURSERY	1,839,264		0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	101,895,897	0	1,967	1,967	50.00
50.01 03020	SAME DAY SURGERY	0	0	0	0	50.01
51.00 05100	RECOVERY ROOM	9,631,553	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	7,352,290	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	14,393,963	0	80	80	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	78,063,076	0	0	0	54.00
54.01 03480	ONCOLOGY	28,614,872	0	0	0	54.01
54.02 03440	MAMMOGRAPHY	8,000,607	0	0	0	54.02
56.00 05600	RADIOLOGY-SOFT COPY	9,882,248	0	0	0	56.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	14,294,824	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	39,062,010	0	0	0	59.00
60.00 06000	LABORATORY	79,259,046	0	0	0	60.00
65.00 06500	RESPIRATORY THERAPY	10,055,755	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	11,711,351	0	1,634	1,634	66.00
69.00 06900	ELECTROCARDIOLOGY	43,387,521	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	1,168,824	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	107,106,059	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	37,908,585	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	1,337,984	0	5,040	5,040	88.00
91.00 09100	EMERGENCY	31,005,079	0	2,726	2,726	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	686,465,198	0	18,592	18,592	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01 19201	FAMILY PRACTICE	0	0	31,048	31,048	192.01
192.02 19202	REFERENCE LAB	0	0	0	0	192.02
192.03 19203	UNUSED SPACE	0	0	0	0	192.03
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)	1,025,594	0	1,585,977	1,183,493	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.001494	0.000000	31.949577	23.841519	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	10,592	0	9,118	8,915	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000015	0.000000	0.183683	0.179593	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140164

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

Worksheet C  
Part I  
Date/Time Prepared:  
8/26/2014 5:56 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	34,165,738		34,165,738	0	34,165,738	30.00
31.00	03100 INTENSIVE CARE UNIT	6,751,706		6,751,706	21,760	6,773,466	31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	2,324,104		2,324,104	29,808	2,353,912	35.00
43.00	04300 NURSERY	351,625		351,625	0	351,625	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	19,252,455		19,252,455	2,586	19,255,041	50.00
50.01	03020 SAME DAY SURGERY	0		0	0	0	50.01
51.00	05100 RECOVERY ROOM	1,438,694		1,438,694	0	1,438,694	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7,510,777		7,510,777	0	7,510,777	52.00
53.00	05300 ANESTHESIOLOGY	918,077		918,077	0	918,077	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	9,461,361		9,461,361	0	9,461,361	54.00
54.01	03480 ONCOLOGY	4,434,251		4,434,251	116,703	4,550,954	54.01
54.02	03440 MAMMOGRAPHY	2,279,349		2,279,349	9,977	2,289,326	54.02
56.00	05600 RADIOISOTOPE	2,060,094		2,060,094	0	2,060,094	56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,477,403		1,477,403	0	1,477,403	58.00
59.00	05900 CARDIAC CATHETERIZATION	14,216,769		14,216,769	14,871	14,231,640	59.00
60.00	06000 LABORATORY	10,486,609		10,486,609	48,267	10,534,876	60.00
65.00	06500 RESPIRATORY THERAPY	2,975,605	0	2,975,605	4,786	2,980,391	65.00
66.00	06600 PHYSICAL THERAPY	4,489,962	0	4,489,962	0	4,489,962	66.00
69.00	06900 ELECTROCARDIOLOGY	9,670,410		9,670,410	0	9,670,410	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	454,138		454,138	0	454,138	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12,852,446		12,852,446	0	12,852,446	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	15,667,119		15,667,119	0	15,667,119	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	11,350,473		11,350,473	0	11,350,473	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	1,944,575		1,944,575	0	1,944,575	88.00
91.00	09100 EMERGENCY	8,413,083		8,413,083	11,657	8,424,740	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4,156,749		4,156,749		4,156,749	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	189,103,572	0	189,103,572	260,415	189,363,987	200.00
201.00	Less Observation Beds	4,156,749		4,156,749		4,156,749	201.00
202.00	Total (see instructions)	184,946,823	0	184,946,823	260,415	185,207,238	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140164

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

Worksheet C  
Part I  
Date/Time Prepared:  
8/26/2014 5:56 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00				
		9.00	10.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	32,816,390		32,816,390			30.00
31.00	03100	INTENSIVE CARE UNIT	5,135,439		5,135,439			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	6,132,631		6,132,631			35.00
43.00	04300	NURSERY	1,839,264		1,839,264			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	58,227,570	42,975,127	101,202,697	0.190237	0.000000	50.00
50.01	03020	SAME DAY SURGERY	0	0	0	0.000000	0.000000	50.01
51.00	05100	RECOVERY ROOM	5,278,445	4,117,602	9,396,047	0.153117	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,306,478	2,989,585	7,296,063	1.029429	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	8,343,406	5,945,395	14,288,801	0.064252	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,675,474	55,531,202	77,206,676	0.122546	0.000000	54.00
54.01	03480	ONCOLOGY	621,205	27,771,336	28,392,541	0.156177	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0	7,878,606	7,878,606	0.289309	0.000000	54.02
56.00	05600	RADIOISOTOPE	3,560,622	10,993,257	14,553,879	0.141549	0.000000	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,682,219	11,231,404	13,913,623	0.106184	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	16,510,824	22,372,265	38,883,089	0.365629	0.000000	59.00
60.00	06000	LABORATORY	38,690,525	39,144,391	77,834,916	0.134729	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,850,561	1,198,492	10,049,053	0.296108	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,882,373	8,554,032	11,436,405	0.392603	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	10,456,440	30,784,664	41,241,104	0.234485	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	689,039	476,220	1,165,259	0.389731	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,012,182	18,336,129	39,348,311	0.326633	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,566,938	24,551,051	53,117,989	0.294949	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,615,261	14,569,655	47,184,916	0.240553	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,337,984	1,337,984			88.00
91.00	09100	EMERGENCY	6,233,675	24,529,820	30,763,495	0.273476	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,002,214	5,331,669	6,333,883	0.656272	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	318,129,175	360,619,886	678,749,061			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	318,129,175	360,619,886	678,749,061			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet C Part I Date/Time Prepared: 8/26/2014 5:56 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT			35.00
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.190262		50.00
50.01	03020 SAME DAY SURGERY	0.000000		50.01
51.00	05100 RECOVERY ROOM	0.153117		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.029429		52.00
53.00	05300 ANESTHESIOLOGY	0.064252		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.122546		54.00
54.01	03480 ONCOLOGY	0.160287		54.01
54.02	03440 MAMMOGRAPHY	0.290575		54.02
56.00	05600 RADIOISOTOPE	0.141549		56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.106184		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.366011		59.00
60.00	06000 LABORATORY	0.135349		60.00
65.00	06500 RESPIRATORY THERAPY	0.296584		65.00
66.00	06600 PHYSICAL THERAPY	0.392603		66.00
69.00	06900 ELECTROCARDIOLOGY	0.234485		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.389731		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.326633		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.294949		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.240553		73.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC			88.00
91.00	09100 EMERGENCY	0.273855		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.656272		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: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet C Part I Date/Time Prepared: 8/26/2014 5:56 pm
		Title XIX	Hospital	Cost

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	34,165,738		34,165,738	0	34,165,738	30.00
31.00 03100 INTENSIVE CARE UNIT	6,751,706		6,751,706	21,760	6,773,466	31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	2,324,104		2,324,104	29,808	2,353,912	35.00
43.00 04300 NURSERY	351,625		351,625	0	351,625	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	19,252,455		19,252,455	2,586	19,255,041	50.00
50.01 03020 SAME DAY SURGERY	0		0	0	0	50.01
51.00 05100 RECOVERY ROOM	1,438,694		1,438,694	0	1,438,694	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	7,510,777		7,510,777	0	7,510,777	52.00
53.00 05300 ANESTHESIOLOGY	918,077		918,077	0	918,077	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	9,461,361		9,461,361	0	9,461,361	54.00
54.01 03480 ONCOLOGY	4,434,251		4,434,251	116,703	4,550,954	54.01
54.02 03440 MAMMOGRAPHY	2,279,349		2,279,349	9,977	2,289,326	54.02
56.00 05600 RADIOISOTOPE	2,060,094		2,060,094	0	2,060,094	56.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1,477,403		1,477,403	0	1,477,403	58.00
59.00 05900 CARDIAC CATHETERIZATION	14,216,769		14,216,769	14,871	14,231,640	59.00
60.00 06000 LABORATORY	10,486,609		10,486,609	48,267	10,534,876	60.00
65.00 06500 RESPIRATORY THERAPY	2,975,605	0	2,975,605	4,786	2,980,391	65.00
66.00 06600 PHYSICAL THERAPY	4,489,962	0	4,489,962	0	4,489,962	66.00
69.00 06900 ELECTROCARDIOLOGY	9,670,410		9,670,410	0	9,670,410	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	454,138		454,138	0	454,138	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12,852,446		12,852,446	0	12,852,446	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	15,667,119		15,667,119	0	15,667,119	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	11,350,473		11,350,473	0	11,350,473	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	1,944,575		1,944,575	0	1,944,575	88.00
91.00 09100 EMERGENCY	8,413,083		8,413,083	11,657	8,424,740	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4,156,749		4,156,749		4,156,749	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	0	189,103,572	260,415	189,363,987	200.00
201.00	Less Observation Beds		4,156,749		4,156,749	201.00
202.00	Total (see instructions)	0	184,946,823	260,415	185,207,238	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140164

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

Worksheet C  
Part I  
Date/Time Prepared:  
8/26/2014 5:56 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	32,816,390		32,816,390		30.00
31.00	03100	INTENSIVE CARE UNIT	5,135,439		5,135,439		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	6,132,631		6,132,631		35.00
43.00	04300	NURSERY	1,839,264		1,839,264		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	58,227,570	42,975,127	101,202,697	0.190237	50.00
50.01	03020	SAME DAY SURGERY	0	0	0	0.000000	50.01
51.00	05100	RECOVERY ROOM	5,278,445	4,117,602	9,396,047	0.153117	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,306,478	2,989,585	7,296,063	1.029429	52.00
53.00	05300	ANESTHESIOLOGY	8,343,406	5,945,395	14,288,801	0.064252	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,675,474	55,531,202	77,206,676	0.122546	54.00
54.01	03480	ONCOLOGY	621,205	27,771,336	28,392,541	0.156177	54.01
54.02	03440	MAMMOGRAPHY	0	7,878,606	7,878,606	0.289309	54.02
56.00	05600	RADIOISOTOPE	3,560,622	10,993,257	14,553,879	0.141549	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,682,219	11,231,404	13,913,623	0.106184	58.00
59.00	05900	CARDIAC CATHETERIZATION	16,510,824	22,372,265	38,883,089	0.365629	59.00
60.00	06000	LABORATORY	38,690,525	39,144,391	77,834,916	0.134729	60.00
65.00	06500	RESPIRATORY THERAPY	8,850,561	1,198,492	10,049,053	0.296108	65.00
66.00	06600	PHYSICAL THERAPY	2,882,373	8,554,032	11,436,405	0.392603	66.00
69.00	06900	ELECTROCARDIOLOGY	10,456,440	30,784,664	41,241,104	0.234485	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	689,039	476,220	1,165,259	0.389731	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,012,182	18,336,129	39,348,311	0.326633	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,566,938	24,551,051	53,117,989	0.294949	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,615,261	14,569,655	47,184,916	0.240553	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	1,337,984	1,337,984	1.453362	88.00
91.00	09100	EMERGENCY	6,233,675	24,529,820	30,763,495	0.273476	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,002,214	5,331,669	6,333,883	0.656272	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	318,129,175	360,619,886	678,749,061		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	318,129,175	360,619,886	678,749,061		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet C Part I Date/Time Prepared: 8/26/2014 5:56 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT			35.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000		50.00
50.01	03020 SAME DAY SURGERY	0.000000		50.01
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03480 ONCOLOGY	0.000000		54.01
54.02	03440 MAMMOGRAPHY	0.000000		54.02
56.00	05600 RADIOISOTOPE	0.000000		56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
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
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
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: 140164		Period: From 04/01/2013 To 03/31/2014		Worksheet D Part I Date/Time Prepared: 8/26/2014 5:56 pm	
Title XVIII		Hospital		PPS			
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,281,953	0	2,281,953	32,524	70.16	30.00
31.00	INTENSIVE CARE UNIT	423,840		423,840	3,827	110.75	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	204,298		204,298	1,644	124.27	35.00
43.00	NURSERY	31,022		31,022	3,096	10.02	43.00
200.00	Total (Lines 30-199)	2,941,113		2,941,113	41,091		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	14,194	995,851				
31.00	INTENSIVE CARE UNIT	2,028	224,601				
35.00	NEONATAL INTENSIVE CARE UNIT	0	0				
43.00	NURSERY	0	0				
200.00	Total (Lines 30-199)	16,222	1,220,452				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140164

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

Worksheet D  
Part II  
Date/Time Prepared:  
8/26/2014 5:56 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,767,109	101,202,697	0.027342	31,861,089	871,146	50.00
50.01	03020 SAME DAY SURGERY	0	0	0.000000	0	0	50.01
51.00	05100 RECOVERY ROOM	91,762	9,396,047	0.009766	2,388,104	23,322	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	397,221	7,296,063	0.054443	36,824	2,005	52.00
53.00	05300 ANESTHESIOLOGY	163,137	14,288,801	0.011417	3,823,155	43,649	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,186,085	77,206,676	0.028315	12,352,122	349,750	54.00
54.01	03480 ONCOLOGY	1,097,269	28,392,541	0.038646	285,974	11,052	54.01
54.02	03440 MAMMOGRAPHY	375,543	7,878,606	0.047666	0	0	54.02
56.00	05600 RADIOISOTOPE	199,739	14,553,879	0.013724	2,404,430	32,998	56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	865,838	13,913,623	0.062230	1,372,414	85,405	58.00
59.00	05900 CARDIAC CATHETERIZATION	1,453,060	38,883,089	0.037370	5,092,089	190,291	59.00
60.00	06000 LABORATORY	510,346	77,834,916	0.006557	21,402,716	140,338	60.00
65.00	06500 RESPIRATORY THERAPY	141,340	10,049,053	0.014065	5,200,653	73,147	65.00
66.00	06600 PHYSICAL THERAPY	65,819	11,436,405	0.005755	1,840,024	10,589	66.00
69.00	06900 ELECTROCARDIOLOGY	657,729	41,241,104	0.015948	6,537,940	104,267	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	79,463	1,165,259	0.068193	315,218	21,496	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	78,774	39,348,311	0.002002	9,940,178	19,900	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	85,306	53,117,989	0.001606	16,415,410	26,363	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	133,652	47,184,916	0.002833	17,466,307	49,482	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	25,827	1,337,984	0.019303	0	0	88.00
91.00	09100 EMERGENCY	730,027	30,763,495	0.023730	3,224,205	76,510	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	277,633	6,333,883	0.043833	456,142	19,994	92.00
200.00	Total (lines 50-199)	12,382,679	632,825,337		142,414,994	2,151,704	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet D Part III Date/Time Prepared: 8/26/2014 5:56 pm
---	--	----------------------	---	---

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
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	35.00
43.00	04300	NURSERY	0	0	0	0	43.00
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	32,524	0.00	14,194	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,827	0.00	2,028	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,644	0.00	0	0	35.00
43.00	04300	NURSERY	3,096	0.00	0	0	43.00
200.00		Total (lines 30-199)	41,091		16,222	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
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0			35.00
43.00	04300	NURSERY	0	0			43.00
200.00		Total (lines 30-199)	0	0			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140164

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

Worksheet D  
Part IV  
Date/Time Prepared:  
8/26/2014 5:56 pm

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
50.01	03020 SAME DAY SURGERY	0	0	0	0	0	50.01
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03480 ONCOLOGY	0	0	0	0	0	54.01
54.02	03440 MAMMOGRAPHY	0	0	0	0	0	54.02
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
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
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet D Part IV Date/Time Prepared: 8/26/2014 5:56 pm
--	----------------------	---	--

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	101,202,697	0.000000	0.000000	31,861,089	50.00
50.01	03020	SAME DAY SURGERY	0	0	0.000000	0.000000	0	50.01
51.00	05100	RECOVERY ROOM	0	9,396,047	0.000000	0.000000	2,388,104	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,296,063	0.000000	0.000000	36,824	52.00
53.00	05300	ANESTHESIOLOGY	0	14,288,801	0.000000	0.000000	3,823,155	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	77,206,676	0.000000	0.000000	12,352,122	54.00
54.01	03480	ONCOLOGY	0	28,392,541	0.000000	0.000000	285,974	54.01
54.02	03440	MAMMOGRAPHY	0	7,878,606	0.000000	0.000000	0	54.02
56.00	05600	RADIOISOTOPE	0	14,553,879	0.000000	0.000000	2,404,430	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	13,913,623	0.000000	0.000000	1,372,414	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	38,883,089	0.000000	0.000000	5,092,089	59.00
60.00	06000	LABORATORY	0	77,834,916	0.000000	0.000000	21,402,716	60.00
65.00	06500	RESPIRATORY THERAPY	0	10,049,053	0.000000	0.000000	5,200,653	65.00
66.00	06600	PHYSICAL THERAPY	0	11,436,405	0.000000	0.000000	1,840,024	66.00
69.00	06900	ELECTROCARDIOLOGY	0	41,241,104	0.000000	0.000000	6,537,940	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,165,259	0.000000	0.000000	315,218	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	39,348,311	0.000000	0.000000	9,940,178	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	53,117,989	0.000000	0.000000	16,415,410	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	47,184,916	0.000000	0.000000	17,466,307	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,337,984	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	30,763,495	0.000000	0.000000	3,224,205	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	6,333,883	0.000000	0.000000	456,142	92.00
200.00		Total (lines 50-199)	0	632,825,337			142,414,994	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet D Part IV Date/Time Prepared: 8/26/2014 5:56 pm
--	----------------------	---	--

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	PPS
ANCILLARY SERVICE COST CENTERS		11.00	12.00	13.00	21.00	22.00	
50.00	05000 OPERATING ROOM	0	17,054,789	0	0	0	50.00
50.01	03020 SAME DAY SURGERY	0	0	0	0	0	50.01
51.00	05100 RECOVERY ROOM	0	3,668,468	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	1,775,179	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	17,987,058	0	0	0	54.00
54.01	03480 ONCOLOGY	0	11,395,660	0	0	0	54.01
54.02	03440 MAMMOGRAPHY	0	0	0	0	0	54.02
56.00	05600 RADIOISOTOPE	0	9,799,246	0	0	0	56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	2,965,415	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	8,333,991	0	0	0	59.00
60.00	06000 LABORATORY	0	3,807,035	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	462,712	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	7,651,706	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	91,341	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,143,570	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	14,097,177	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	5,298,920	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100 EMERGENCY	0	5,182,530	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,704,870	0	0	0	92.00
200.00	Total (lines 50-199)	0	118,419,667	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet D Part IV Date/Time Prepared: 8/26/2014 5:56 pm
	Title XVIII	Hospital	PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
50.01	03020 SAME DAY SURGERY	0	0	50.01
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03480 ONCOLOGY	0	0	54.01
54.02	03440 MAMMOGRAPHY	0	0	54.02
56.00	05600 RADIOISOTOPE	0	0	56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
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
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
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: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet D Part V Date/Time Prepared: 8/26/2014 5:56 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.190237	17,054,789	0	0	3,244,452	50.00
50.01	03020	SAME DAY SURGERY	0.000000	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0.153117	3,668,468	0	0	561,705	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.029429	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.064252	1,775,179	0	0	114,059	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.122546	17,987,058	0	0	2,204,242	54.00
54.01	03480	ONCOLOGY	0.156177	11,395,660	0	0	1,779,740	54.01
54.02	03440	MAMMOGRAPHY	0.289309	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0.141549	9,799,246	0	0	1,387,073	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.106184	2,965,415	0	0	314,880	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.365629	8,333,991	0	0	3,047,149	59.00
60.00	06000	LABORATORY	0.134729	3,807,035	6,630	0	512,918	60.00
65.00	06500	RESPIRATORY THERAPY	0.296108	462,712	0	0	137,013	65.00
66.00	06600	PHYSICAL THERAPY	0.392603	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.234485	7,651,706	0	0	1,794,210	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.389731	91,341	0	0	35,598	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.326633	7,143,570	0	0	2,333,326	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.294949	14,097,177	0	0	4,157,948	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.240553	5,298,920	142	99,615	1,274,671	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.273476	5,182,530	0	0	1,417,298	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.656272	1,704,870	0	0	1,118,858	92.00
200.00		Subtotal (see instructions)		118,419,667	6,772	99,615	25,435,140	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		118,419,667	6,772	99,615	25,435,140	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet D Part V Date/Time Prepared: 8/26/2014 5:56 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
50.01	03020 SAME DAY SURGERY	0	0	50.01
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03480 ONCOLOGY	0	0	54.01
54.02	03440 MAMMOGRAPHY	0	0	54.02
56.00	05600 RADIOISOTOPE	0	0	56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	893	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
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	34	23,963	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Subtotal (see instructions)	927	23,963	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	927	23,963	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 8/26/2014 5:56 pm
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		32,524	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		32,524	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)		28,567	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)		14,194	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		34,165,738	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)		34,165,738	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		34,165,738	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,050.48	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		14,910,513	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)		14,910,513	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140164		Period: From 04/01/2013 To 03/31/2014		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 8/26/2014 5:56 pm	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	6,773,466	3,827	1,769.92	2,028	3,589,398		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 NEONATAL INTENSIVE CARE UNIT	2,353,912	1,644	1,431.82	0	0		47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					30,910,496		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					49,410,407		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,220,452		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,151,704		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					3,372,156		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					46,038,251		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)					3,957		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,050.48		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					4,156,749		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140164		Period: From 04/01/2013 To 03/31/2014		Worksheet D-1 Date/Time Prepared: 8/26/2014 5:56 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,281,953	34,165,738	0.066791	4,156,749	277,633	90.00
91.00	Nursing School cost	0	34,165,738	0.000000	4,156,749	0	91.00
92.00	Allied health cost	0	34,165,738	0.000000	4,156,749	0	92.00
93.00	All other Medical Education	0	34,165,738	0.000000	4,156,749	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet D-3 Date/Time Prepared: 8/26/2014 5:56 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		13,396,544	30.00
31.00	03100	INTENSIVE CARE UNIT		2,918,648	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0	35.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.190262	31,861,089	50.00
50.01	03020	SAME DAY SURGERY	0.000000	0	50.01
51.00	05100	RECOVERY ROOM	0.153117	2,388,104	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.029429	36,824	52.00
53.00	05300	ANESTHESIOLOGY	0.064252	3,823,155	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.122546	12,352,122	54.00
54.01	03480	ONCOLOGY	0.160287	285,974	54.01
54.02	03440	MAMMOGRAPHY	0.290575	0	54.02
56.00	05600	RADIOISOTOPE	0.141549	2,404,430	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.106184	1,372,414	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.366011	5,092,089	59.00
60.00	06000	LABORATORY	0.135349	21,402,716	60.00
65.00	06500	RESPIRATORY THERAPY	0.296584	5,200,653	65.00
66.00	06600	PHYSICAL THERAPY	0.392603	1,840,024	66.00
69.00	06900	ELECTROCARDIOLOGY	0.234485	6,537,940	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.389731	315,218	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.326633	9,940,178	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.294949	16,415,410	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.240553	17,466,307	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
91.00	09100	EMERGENCY	0.273855	3,224,205	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.656272	456,142	92.00
200.00		Total (sum of lines 50-94 and 96-98)		142,414,994	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		142,414,994	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet E Part A Date/Time Prepared: 8/26/2014 5:56 pm	
		Title XVIII	Hospital		PPS
		0	before 1/1	on/after 1/1	2.00
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER PPS</b>					
1.00	DRG Amounts Other than Outlier Payments		0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013 (see instructions)		18,049,307		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		17,269,336		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)		1,032,083		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		1,693,588		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		157.16		4.00
<b>Indirect Medical Education Adjustment</b>					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		5.17		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)		5.17		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		15.00		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)		5.17		12.00
13.00	Total allowable FTE count for the prior year.		5.17		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.		5.17		14.00
15.00	Sum of lines 12 through 14 divided by 3.		5.17		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		5.17		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.032896		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.034975		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.032896		21.00
22.00	IME payment adjustment (see instructions)		659,299		22.00
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		7.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		9.83		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)		7.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.044541		26.00
27.00	IME payments adjustment factor. (see instructions)		0.011752		27.00
28.00	IME add-on adjustment amount (see instructions)		434,968		28.00
29.00	Total IME payment ( sum of lines 22 and 28)		1,094,267		29.00
<b>Disproportionate Share Adjustment</b>					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		6.91		30.00
31.00	Percentage of Medicaid patient days (see instructions)		27.82		31.00
32.00	Sum of lines 30 and 31		34.73		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet E Part A Date/Time Prepared: 8/26/2014 5:56 pm	
		Title XVIII	Hospital		PPS
		0	before 1/1	on/after 1/1	2.00
33.00	Allowable disproportionate share percentage (see instructions)		17.87	1.01	33.00
34.00	Disproportionate share adjustment (see instructions)		3,996,919		34.00
			Prior to October 1		On/After October 1
		0	1.00	1.01	2.00
<b>Uncompensated Care Adjustment</b>					
35.00	Total uncompensated care amount (see instructions)				9,046,380,143 35.00
35.01	Factor 3 (see instructions)				0.000321715 35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)				2,870,377 35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)				1,431,256 35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,431,256		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0		46.00
47.00	Subtotal (see instructions)		42,873,168		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)		42,873,168		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		3,060,529		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).		403,810		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		2,713		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0		55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0		56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).		0		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		46,340,220		59.00
60.00	Primary payer payments		33,186		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		46,307,034		61.00
62.00	Deductibles billed to program beneficiaries		3,551,712		62.00
63.00	Coinurance billed to program beneficiaries		55,984		63.00
64.00	Allowable bad debts (see instructions)		941,209		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		611,786		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		806,205		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		43,311,124		67.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet E Part A Date/Time Prepared: 8/26/2014 5:56 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	1.01	On/After October 1 2.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0		68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.92	Bundled Model 1 discount amount		0		70.92
70.93	HVBP incentive payment (see instructions)		-45,795		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		-19,777		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)		43,245,552		71.00
71.01	Sequestration adjustment (see instructions)		864,911		71.01
72.00	Interim payments		42,167,565		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		213,076		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		39,975		75.00
<b>TO BE COMPLETED BY CONTRACTOR</b>					
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the Time Value of Money		0.00		94.00
95.00	Time Value of Money for operating expenses(see instructions)		0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)		0		96.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140164		Period: From 04/01/2013 To 03/31/2014		Worksheet DSH	
		Title XVIII		Hospital		Date/Time Prepared: 8/26/2014 5:56 pm	
		PPS					
		Original .mcrcx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
<b>CALCULATION OF THE DSH PAYMENT PERCENTAGE</b>							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	6.91	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	27.82	0.00			27.82	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	34.73	0.00			27.82	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	RRC				RRC	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	157.16	0.00			157.16	5.00
6.00	Disproportionate Share Payment Percentage (transfer to Worksheet E, Part A, line 33)	17.87	0.00			12.17	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No				No	9.00
10.00	S-2, Line 45	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
<b>CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS</b>							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	8,800	0			8,800	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	99	0			99	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	1	0			1	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)	107	0			107	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	1,607	0			1,607	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	10,614	0			10,614	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	37,134	0			37,134	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	1,018	0			1,018	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)	38,152	0			38,152	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	27.82	0.00			27.82	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140164		Period: From 04/01/2013 To 03/31/2014		Worksheet DSH Date/Time Prepared: 8/26/2014 5:56 pm	
		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
<b>CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE</b>							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	17.87		0.00	True	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False	29.00
30.00	Line 28 or 29 as applicable		17.87		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		17.87		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
<b>DETERMINATION OF PROVIDER TYPE</b>							
32.00	Does the hospital qualify under the Pickle amendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	True				True	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Rural				Rural	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet DSH Date/Time Prepared: 8/26/2014 5:56 pm
		Title XVIII	Hospital	PPS

		Revised	
		Percentage	
		6.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	12.17	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00	29.00
30.00	Line 28 or 29 as applicable	12.17	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.	12.17	31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet E Part B Date/Time Prepared: 8/26/2014 5:56 pm
		Title XVII	Hospital	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		24,890	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		25,435,140	2.00
3.00	PPS payments		21,594,923	3.00
4.00	Outlier payment (see instructions)		233,359	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.872	5.00
6.00	Line 2 times line 5		22,179,442	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		98.42	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)		24,890	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		106,387	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)		106,387	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		106,387	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		81,497	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)		24,890	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		21,828,282	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		4,405,803	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)		17,447,369	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		211,192	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)		17,658,561	30.00
31.00	Primary payer payments		2,748	31.00
32.00	Subtotal (line 30 minus line 31)		17,655,813	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		1,048,891	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		681,779	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		951,114	36.00
37.00	Subtotal (see instructions)		18,337,592	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-256	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		18,337,848	40.00
40.01	Sequestration adjustment (see instructions)		366,757	40.01
41.00	Interim payments		17,830,150	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		140,941	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00
			Overrides	
			1.00	
<b>WORKSHEET OVERRIDE VALUES</b>				
112.00	Override of Ancillary service charges (line 12)			0
				112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140164

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
8/26/2014 5:56 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		41,999,953		17,712,447	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02		03/25/2014	186,340	10/29/2013	117,703	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		10/29/2013	18,728		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)		167,612		117,703	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)		42,167,565		17,830,150	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		213,076		140,941	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		42,380,641		17,971,091	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet E-1 Part II Date/Time Prepared: 8/26/2014 5:56 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			10,155 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			16,222 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			698 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			34,038 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			678,749,061 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			25,498,277 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			1,963,320 8.00
9.00	Sequestration adjustment amount (see instructions)			0 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			1,963,320 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			1,926,934 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			36,386 32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			0 108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet E-3 Part VII Date/Time Prepared: 8/26/2014 5:56 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0	43.00
<b>OVERRIDES</b>					
109.00	Override Ancillary service charges (line 9)		0	0	109.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet E-4 Date/Time Prepared: 8/26/2014 5:56 pm	
		Title XVII	Hospital	PPS	
				1.00	
<b>COMPUTATION OF TOTAL DIRECT GME AMOUNT</b>					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			15.80	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			15.80	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			15.00	6.00
7.00	Enter the lesser of line 5 or line 6			15.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	15.00	0.00	15.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	15.00	0.00	15.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
11.00	Total weighted FTE count	15.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	15.66	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	15.80	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	15.49	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
17.00	Adjusted rolling average FTE count	15.49	0.00		17.00
18.00	Per resident amount	80,339.23	0.00		18.00
19.00	Approved amount for resident costs	1,244,455	0	1,244,455	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			1,244,455	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
<b>COMPUTATION OF PROGRAM PATIENT LOAD</b>					
26.00	Inpatient Days (see instructions)	16,222	698		26.00
27.00	Total Inpatient Days (see instructions)	34,038	34,038		27.00
28.00	Ratio of inpatient days to total inpatient days	0.476585	0.020506		28.00
29.00	Program direct GME amount	593,089	25,519		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		3,606		30.00
31.00	Net Program direct GME amount			615,002	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet E-4 Date/Time Prepared: 8/26/2014 5:56 pm
		Title XVIII	Hospital	PPS
				1.00
<b>DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)</b>				
32.00	Renal dialysis direct medical education costs (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Worksheet C, Part I, column 8, sum of lines 74 and 94)		0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
<b>APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY</b>				
<b>Part A Reasonable Cost</b>				
37.00	Reasonable cost (see instructions)		49,410,407	37.00
38.00	Organ acquisition costs (Worksheet D-4, Part III, column 1, line 69)		0	38.00
39.00	Cost of teaching physicians (Worksheet D-5, Part II, column 3, line 20)		0	39.00
40.00	Primary payer payments (see instructions)		33,186	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		49,377,221	41.00
<b>Part B Reasonable Cost</b>				
42.00	Reasonable cost (see instructions)		25,826,996	42.00
43.00	Primary payer payments (see instructions)		2,748	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		25,824,248	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		75,201,469	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.656599	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.343401	47.00
<b>ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B</b>				
48.00	Total program GME payment (line 31)		615,002	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (Title XVIII only) (see instructions)		403,810	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (Title XVIII only) (see instructions)		211,192	50.00

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

Provider CCN: 140164

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

Worksheet G

Date/Time Prepared:  
8/26/2014 5:56 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	4,705,859	19,931	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	16,417	0	0	0	3.00
4.00	Accounts receivable	133,607,210	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-86,218,087	0	0	0	6.00
7.00	Inventory	4,965,865	0	0	0	7.00
8.00	Prepaid expenses	861,685	0	0	0	8.00
9.00	Other current assets	355,798	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)	58,294,747	19,931	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	5,937,499	0	0	0	12.00
13.00	Land improvements	3,264,065	0	0	0	13.00
14.00	Accumulated depreciation	-2,509,446	0	0	0	14.00
15.00	Buildings	105,690,389	0	0	0	15.00
16.00	Accumulated depreciation	-63,225,056	0	0	0	16.00
17.00	Leasehold improvements	163,698	0	0	0	17.00
18.00	Accumulated depreciation	-88,538	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	657,817	0	0	0	21.00
22.00	Accumulated depreciation	-205,967	0	0	0	22.00
23.00	Major movable equipment	57,668,361	0	0	0	23.00
24.00	Accumulated depreciation	-39,795,840	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	17,445,224	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	85,002,206	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	215,636,657	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,473,577	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	218,110,234	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	361,407,187	19,931	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	9,195,185	0	0	0	37.00
38.00	Salaries, wages, and fees payable	7,487,814	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	3,549,853	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	6,964,977	0	0	0	43.00
44.00	Other current liabilities	5,421,279	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	32,619,108	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	72,663,520	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	2,624,620	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	75,288,140	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	107,907,248	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	253,499,939				52.00
53.00	Specific purpose fund		19,931			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)	253,499,939	19,931	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	361,407,187	19,931	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140164

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

Worksheet G-1

Date/Time Prepared:  
8/26/2014 5:56 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		231,113,541		20,422	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		22,386,397			2.00
3.00	Total (sum of line 1 and line 2)		253,499,938		20,422	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00	ROUNDING	1		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)		1		0	10.00
11.00	Subtotal (line 3 plus line 10)		253,499,939		20,422	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00	GRANT TRANSACTIONS	0		491		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		491	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		253,499,939		19,931	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00	ROUNDING		0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00	GRANT TRANSACTIONS		0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 140164

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
8/26/2014 5:56 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	41,064,516		41,064,516	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	41,064,516		41,064,516	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,135,439		5,135,439	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	NEONATAL INTENSIVE CARE UNIT	6,133,699		6,133,699	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	11,269,138		11,269,138	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	52,333,654		52,333,654	17.00
18.00	Ancillary services	272,059,902	360,733,659	632,793,561	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	1,337,984	1,337,984	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	324,393,556	362,071,643	686,465,199	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		190,874,966		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		190,874,966		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140164

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

Worksheet G-3

Date/Time Prepared:  
8/26/2014 5:56 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	686,465,199	1.00
2.00	Less contractual allowances and discounts on patients' accounts	460,122,344	2.00
3.00	Net patient revenues (line 1 minus line 2)	226,342,855	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	190,874,966	4.00
5.00	Net income from service to patients (line 3 minus line 4)	35,467,889	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	23,119,924	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	6,248	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	941,186	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	1,676	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	62,190	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	19,112	21.00
22.00	Rental of hospital space	534,230	22.00
23.00	Governmental appropriations	4,050,156	23.00
24.00	MISCELLANEOUS	43,947	24.00
25.00	Total other income (sum of lines 6-24)	28,778,669	25.00
26.00	Total (line 5 plus line 25)	64,246,558	26.00
27.00	CORP ALLOC/CONTRIBUTIONS	41,860,161	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	41,860,161	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	22,386,397	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet L Parts I-III Date/Time Prepared: 8/26/2014 5:56 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		2,775,175	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		181,285	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)		93.25	3.00
4.00	Number of interns & residents (see instructions)		12.17	4.00
5.00	Indirect medical education percentage (see instructions)		3.75	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)		104,069	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)		3,060,529	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 140164  
Component CCN: 143454

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

Worksheet M-1  
Date/Time Prepared:  
8/26/2014 5:56 pm

				Rural Health Clinic (RHC) I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	Reclassified	
		1.00	2.00	3.00	4.00	5.00	
						Reclassified	Trial Balance (col. 3 + col. 4)
<b>FACILITY HEALTH CARE STAFF COSTS</b>							
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	120,870	0	120,870	0	120,870	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	28,256	0	28,256	0	28,256	9.00
10.00	Subtotal (sum of lines 1-9)	149,126	0	149,126	0	149,126	10.00
11.00	Physician Services Under Agreement	509,931	0	509,931	0	509,931	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	204,630	0	204,630	0	204,630	13.00
14.00	Subtotal (sum of lines 11-13)	714,561	0	714,561	0	714,561	14.00
15.00	Medical Supplies	0	55,999	55,999	-4,762	51,237	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	161,026	120,161	281,187	0	281,187	20.00
21.00	Subtotal (sum of lines 15-20)	161,026	176,160	337,186	-4,762	332,424	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	863,687	55,999	919,686	-4,762	914,924	22.00
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
<b>FACILITY OVERHEAD</b>							
29.00	Facility Costs	0	82,920	82,920	0	82,920	29.00
30.00	Administrative Costs	258,687	48,110	306,797	0	306,797	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	258,687	131,030	389,717	0	389,717	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,122,374	187,029	1,309,403	-4,762	1,304,641	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 140164 Component CCN: 143454	Period: From 04/01/2013 To 03/31/2014	Worksheet M-1 Date/Time Prepared: 8/26/2014 5:56 pm
		Rural Health Clinic (RHC) I	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
<b>FACILITY HEALTH CARE STAFF COSTS</b>			
1.00	Physician	0	0
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	0
4.00	Visiting Nurse	0	120,870
5.00	Other Nurse	0	0
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	28,256
10.00	Subtotal (sum of lines 1-9)	0	149,126
11.00	Physician Services Under Agreement	0	509,931
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	204,630
14.00	Subtotal (sum of lines 11-13)	0	714,561
15.00	Medical Supplies	0	51,237
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs	0	281,187
21.00	Subtotal (sum of lines 15-20)	0	332,424
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	914,924
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0
<b>FACILITY OVERHEAD</b>			
29.00	Facility Costs	0	82,920
30.00	Administrative Costs	-29,136	277,661
31.00	Total Facility Overhead (sum of lines 29 and 30)	-29,136	360,581
32.00	Total facility costs (sum of lines 22, 28 and 31)	-29,136	1,275,505

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet M-2		
		Component CCN: 143454		Date/Time Prepared: 8/26/2014 5:56 pm		
			Rural Health Clinic (RHC) I	Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
<b>VISITS AND PRODUCTIVITY</b>						
<b>Positions</b>						
1.00	Physician	0.00	0	4,200	0	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.00	0	2,100	0	3.00
4.00	Subtotal (sum of lines 1-3)	0.00	0		0	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	0.00	0		0	8.00
9.00	Physician Services Under Agreements		20,542		20,542	9.00
					1.00	
<b>DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES</b>						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)				914,924	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				914,924	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)				360,581	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				669,070	15.00
16.00	Total overhead (sum of lines 14 and 15)				1,029,651	16.00
17.00	Allowable GME overhead (see instructions)				97,191	17.00
18.00	Subtract line 17 from line 16				932,460	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				932,460	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				1,847,384	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 140164	Period: From 04/01/2013 To 03/31/2014	Worksheet M-3
		Component CCN: 143454		Date/Time Prepared: 8/26/2014 5:56 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		1,847,384	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		22,792	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,824,592	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		0	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		20,542	5.00
6.00	Total adjusted visits (line 4 plus line 5)		20,542	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		88.82	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.17	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	79.17	79.80	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	2,327	698	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	184,229	55,700	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		127,037	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		366,966	16.00
16.01	Total program charges (see instructions)(from contractor's records)		348,683	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		263,619	16.04
16.05	Total program cost (see instructions)		263,619	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		37,442	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		62,248	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		263,619	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		6,820	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		270,439	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		270,439	26.00
26.01	Sequestration adjustment (see instructions)		5,409	26.01
27.00	Interim payments		156,758	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program line 26 minus lines 26.01, 27 and 28		108,272	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 140164 Component CCN: 143454	Period: From 04/01/2013 To 03/31/2014	Worksheet M-4 Date/Time Prepared: 8/26/2014 5:56 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	149,126	149,126	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001723	0.006776	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	257	1,010	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	5,584	3,873	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	5,841	4,883	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	914,924	914,924	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	1,029,651	1,029,651	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.006384	0.005337	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	6,573	5,495	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	12,414	10,378	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	90	354	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	137.93	29.32	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	8	195	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	1,103	5,717	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		22,792	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		6,820	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140164 Component CCN: 143454	Period: From 04/01/2013 To 03/31/2014	Worksheet M-5 Date/Time Prepared: 8/26/2014 5:56 pm
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		156,758	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	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		156,758	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		108,272	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		265,030	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00