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: 140151	Period: From 07/01/2012 To 07/20/2013	Worksheet S Parts I-III Date/Time Prepared: 5/7/2014 3:38 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/7/2014 Time: 3:38 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] 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 SACRED HEART HOSPITAL (140151) for the cost reporting period beginning 07/01/2012 and ending 07/20/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

DAVID MCLAUGHLIN, SENIOR DIRECTOR, A
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	527	430,727	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	527	430,727	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet S-2 Part I | Date/Time Prepared: 5/7/2014 3:38 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 3240 W. FRANKLIN BLVD	PO Box:			1.00
2.00	City: CHICAGO	State: IL	Zip Code: 60624	County: COOK	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	SACRED HEART HOSPITAL	140151	16974	1	07/01/1988	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2012	07/20/2013	20.00
21.00	Type of Control (see instructions)	4		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	N	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	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	3,610	0	0	0	213	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	25.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet S-2 Part I | Date/Time Prepared: 5/7/2014 3:38 pm

		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)			39.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	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	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet S-2 Part I Date/Time Prepared: 5/7/2014 3:38 pm

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings					
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet S-2 Part I | Date/Time Prepared: 5/7/2014 3:38 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have 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
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140151	Period: From 07/01/2012 To 07/20/2013	Worksheet S-2 Part I Date/Time Prepared: 5/7/2014 3:38 pm

		V	XIX	
		1.00	2.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	368,861	0	0	118.01

		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
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140151	Period: From 07/01/2012 To 07/20/2013	Worksheet S-2 Part I Date/Time Prepared: 5/7/2014 3:38 pm

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	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)	0.00	169.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet S-2 Part II | Date/Time Prepared: 5/7/2014 3:38 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.	Y	07/20/2013	I	2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N	C		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	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.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	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	04/22/2014	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: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet S-2 Part II Date/Time Prepared: 5/7/2014 3:38 pm

		Description	Part A Y/N	Part A Date	Part B 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	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			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.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TONY	LEONE	41.00
42.00	Enter the employer/company name of the cost report preparer.	LEONE REIMBURSEMENT&CONSULTING		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	847/275/1023	TONY@LEONE-CONSULTING.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet S-2 Part II | Date/Time Prepared: 5/7/2014 3:38 pm

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	04/22/2014			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		CONSULTANT		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet S-3 Part I Date/Time Prepared: 5/7/2014 3:38 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	111	40,626	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)		111	40,626	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	8	2,928	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		119	43,554	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		119				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet S-3 Part I | Date/Time Prepared: 5/7/2014 3:38 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,451	3,194	11,416			1.00
2.00	HMO and other (see instructions)	9	213				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)	6,451	3,194	11,416			7.00
8.00	INTENSIVE CARE UNIT	1,040	416	1,632			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	7,491	3,610	13,048	5.30	240.16	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				5.30	240.16	27.00
28.00	Observation Bed Days		125	332			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet S-3 Part I | Date/Time Prepared: 5/7/2014 3:38 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,438	866	2,721	1.00
2.00	HMO and other (see instructions)			4			2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,438	866	2,721	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						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet S-3 Part II Date/Time Prepared: 5/7/2014 3:38 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	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	12,143,309	0	12,143,309	482,979.00	25.14	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		255,948	0	255,948	3,240.00	79.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	189,539	0	189,539	12,480.00	15.19	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		314,615	146,013	460,628	15,308.00	30.09	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		0	0	0	0.00	0.00	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		1,834,646	0	1,834,646			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		75,205	0	75,205			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		41,787	0	41,787			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		30,945	0	30,945			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	2,159,216	-101,661	2,057,555	68,354.00	30.10	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	148,717	0	148,717	7,390.00	20.12	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	206,595	0	206,595	20,615.00	10.02	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	286,952	-81,032	205,920	13,752.00	14.97	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	81,032	81,032	5,411.00	14.98	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	200,235	0	200,235	4,731.00	42.32	38.00
39.00	Central Services and Supply	14.00	75,605	0	75,605	4,181.00	18.08	39.00
40.00	Pharmacy	15.00	405,160	0	405,160	11,762.00	34.45	40.00
41.00	Medical Records & Medical Records Library	16.00	187,779	0	187,779	8,651.00	21.71	41.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet S-3 Part II Date/Time Prepared: 5/7/2014 3:38 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	
42.00	Social Service	17.00	46,103	0	46,103	1,959.00	23.53	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet S-3 Part III Date/Time Prepared: 5/7/2014 3:38 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	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		11,697,822	0	11,697,822	467,259.00	25.03	1.00
2.00	Excluded area salaries (see instructions)		314,615	146,013	460,628	15,308.00	30.09	2.00
3.00	Subtotal salaries (line 1 minus line 2)		11,383,207	-146,013	11,237,194	451,951.00	24.86	3.00
4.00	Subtotal other wages & related costs (see inst.)		0	0	0	0.00	0.00	4.00
5.00	Subtotal wage-related costs (see inst.)		1,834,646	0	1,834,646	0.00	16.33	5.00
6.00	Total (sum of lines 3 thru 5)		13,217,853	-146,013	13,071,840	451,951.00	28.92	6.00
7.00	Total overhead cost (see instructions)		3,716,362	-101,661	3,614,701	146,806.00	24.62	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet S-3 Part IV Date/Time Prepared: 5/7/2014 3:38 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	49,962	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	528,592	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	17,633	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	10,990	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)	58,861	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	112,124	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	880,057	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	11,735	19.00
20.00	State or Federal Unemployment Taxes	312,631	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	1,982,585	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COST	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet S-3 Part V Date/Time Prepared: 5/7/2014 3:38 pm

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140151	Period: From 07/01/2012 To 07/20/2013	Worksheet S-10 Date/Time Prepared: 5/7/2014 3:38 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.324545	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,008,800	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	8,291,914	5.00
6.00	Medicaid charges	15,779,886	6.00
7.00	Medicaid cost (line 1 times line 6)	5,121,283	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	218,038	0	218,038	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	70,763	0	70,763	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)	70,763	0	70,763	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	5,809,957	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	995,657	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	4,814,300	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,562,457	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,633,220	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,633,220	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet A | Date/Time Prepared: 5/7/2014 3:38 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		849,600	849,600	-249,600	600,000	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	861,589	861,589	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,107,827	1,107,827	0	1,107,827	4.00
5.10	00540	NONPATIENT TELEPHONES	29,227	139,751	168,978	0	168,978	5.10
5.20	00550	DATA PROCESSING	142,874	200,722	343,596	0	343,596	5.20
5.30	00560	PURCHASING	76,982	10,499	87,481	0	87,481	5.30
5.40	00580	CASHIERING	582,117	144,315	726,432	0	726,432	5.40
5.50	00590	ADMINISTRATIVE & GENERAL	1,328,016	4,812,330	6,140,346	-713,650	5,426,696	5.50
6.00	00600	MAINTENANCE & REPAIRS	148,717	156,902	305,619	0	305,619	6.00
7.00	00700	OPERATION OF PLANT	0	806,790	806,790	0	806,790	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	155,767	155,767	8.00
9.00	00900	HOUSEKEEPING	206,595	226,059	432,654	-155,767	276,887	9.00
10.00	01000	DIETARY	286,952	434,866	721,818	-203,834	517,984	10.00
11.00	01100	CAFETERIA	0	0	0	203,834	203,834	11.00
13.00	01300	NURSING ADMINISTRATION	200,235	79,219	279,454	0	279,454	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	75,605	145,323	220,928	-130,153	90,775	14.00
15.00	01500	PHARMACY	405,160	783,525	1,188,685	-654,738	533,947	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	187,779	120,484	308,263	0	308,263	16.00
17.00	01700	SOCIAL SERVICE	46,103	3,423	49,526	0	49,526	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	189,539	90,321	279,860	0	279,860	21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,644,436	528,513	3,172,949	-141,150	3,031,799	30.00
31.00	03100	INTENSIVE CARE UNIT	971,071	98,930	1,070,001	-6,607	1,063,394	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	834,014	1,010,319	1,844,333	-829,007	1,015,326	50.00
51.00	05100	RECOVERY ROOM	114,631	13,792	128,423	-5,277	123,146	51.00
53.00	05300	ANESTHESIOLOGY	87,805	647,488	735,293	-22,536	712,757	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	725,945	485,780	1,211,725	-33,898	1,177,827	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	622,856	896,847	1,519,703	-112,114	1,407,589	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	338,656	234,394	573,050	-11,628	561,422	65.00
66.00	06600	PHYSICAL THERAPY	193,080	31,392	224,472	-1,587	222,885	66.00
69.00	06900	ELECTROCARDIOLOGY	51,755	6,867	58,622	-691	57,931	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	64,080	64,080	0	64,080	70.00
70.50	03951	SLEEP LAB	18,059	1,418	19,477	-67	19,410	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	0	0	0	1,084,113	1,084,113	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	128,393	128,393	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	643,415	643,415	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	113,400	113,400	74.00
76.00	03950	INDUSTRIAL MEDICINE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	768,750	525,988	1,294,738	-52,746	1,241,992	90.00
91.00	09100	EMERGENCY	551,735	812,690	1,364,425	-11,474	1,352,951	91.00
92.00	09200	OBSERVATION BEDS						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,828,694	15,470,454	27,299,148	-146,013	27,153,135	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	314,615	523,442	838,057	44,352	882,409	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	101,661	101,661	194.00
200.00		TOTAL (SUM OF LINES 118-199)	12,143,309	15,993,896	28,137,205	0	28,137,205	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet A | Date/Time Prepared: 5/7/2014 3:38 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-596,155	3,845		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-141,522	720,067		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	24,321	1,132,148		4.00
5.10	00540	NONPATIENT TELEPHONES	6,723	175,701		5.10
5.20	00550	DATA PROCESSING	21,206	364,802		5.20
5.30	00560	PURCHASING	4,333	91,814		5.30
5.40	00580	CASHIERING	19,005	745,437		5.40
5.50	00590	ADMINISTRATIVE & GENERAL	-766,466	4,660,230		5.50
6.00	00600	MAINTENANCE & REPAIRS	10,540	316,159		6.00
7.00	00700	OPERATION OF PLANT	78,927	885,717		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	155,767		8.00
9.00	00900	HOUSEKEEPING	5,358	282,245		9.00
10.00	01000	DIETARY	7,597	525,581		10.00
11.00	01100	CAFETERIA	-36,101	167,733		11.00
13.00	01300	NURSING ADMINISTRATION	8,501	287,955		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,495	92,270		14.00
15.00	01500	PHARMACY	11,021	544,968		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,426	313,689		16.00
17.00	01700	SOCIAL SERVICE	0	49,526		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	-28,256	251,604		21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-128,562	2,903,237		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,063,394		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,015,326		50.00
51.00	05100	RECOVERY ROOM	0	123,146		51.00
53.00	05300	ANESTHESIOLOGY	-704,381	8,376		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,006	1,187,833		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	-19,989	1,387,600		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	709	562,131		65.00
66.00	06600	PHYSICAL THERAPY	0	222,885		66.00
69.00	06900	ELECTROCARDIOLOGY	0	57,931		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-47,720	16,360		70.00
70.50	03951	SLEEP LAB	0	19,410		70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	0	1,084,113		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	128,393		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-4,377	639,038		73.00
74.00	07400	RENAL DIALYSIS	-103,075	10,325		74.00
76.00	03950	INDUSTRIAL MEDICINE	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-380,959	861,033		90.00
91.00	09100	EMERGENCY	-728,585	624,366		91.00
92.00	09200	OBSERVATION BEDS				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,470,980	23,682,155		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,523	887,932		192.00
194.00	07950	OTHER NONREIMBURSABLE	0	101,661		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-3,465,457	24,671,748		200.00

RECLASSIFICATIONS | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet A-6 | Date/Time Prepared: 5/7/2014 3:38 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RECLASS CAFETERIA COSTS				
1.00	CAFETERIA	11.00	81,032	122,802	1.00
	TOTALS		81,032	122,802	
	B - RECLASS SUPPLY COSTS				
1.00	MEDICAL SUPPLIES CHRGED TO PATIENTS	71.00	0	1,212,506	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	1,212,506	
	C - RECLASS DEPRECIATION EXPENSE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	849,600	1.00
	TOTALS		0	849,600	
	D - DRUGS SOLD TO PATIENTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	643,415	1.00
	TOTALS		0	643,415	
	E - RENAL RECLASS				
1.00	RENAL DIALYSIS	74.00	0	113,400	1.00
	TOTALS		0	113,400	
	F - RECLASS INTEREST EXPENSE ON LEASES				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	11,989	1.00
	TOTALS		0	11,989	
	G - RECLASS SUBSIDIARY COSTS				
1.00	OTHER NONREIMBURSABLE	194.00	101,661	0	1.00
	TOTALS		101,661	0	
	H - RECLASS LAUNDRY EXPENSES				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	155,767	1.00
	TOTALS		0	155,767	
	I - RECLASS CLINIC DIRECTOR COSTS				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	44,352	0	1.00
	TOTALS		44,352	0	
	J - RECLASS IMPLANT COSTS				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	128,393	1.00
	TOTALS		0	128,393	
	K - RENTAL RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	600,000	1.00
	TOTALS		0	600,000	
500.00	Grand Total: Increases		227,045	3,837,872	500.00

RECLASSIFICATIONS | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet A-6 | Date/Time Prepared: 5/7/2014 3:38 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	81,032	122,802	0		1.00
	TOTALS		81,032	122,802			
	B - RECLASS SUPPLY COSTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	130,153	0		1.00
2.00	PHARMACY	15.00	0	11,323	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	27,750	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	6,607	0		4.00
5.00	OPERATING ROOM	50.00	0	829,007	0		5.00
6.00	RECOVERY ROOM	51.00	0	5,277	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	22,536	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	33,350	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	548	0		9.00
10.00	LABORATORY	60.00	0	112,114	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	11,628	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	1,587	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	691	0		13.00
14.00	SLEEP LAB	70.50	0	67	0		14.00
15.00	CLINIC	90.00	0	8,394	0		15.00
16.00	EMERGENCY	91.00	0	11,474	0		16.00
	TOTALS		0	1,212,506			
	C - RECLASS DEPRECIATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	849,600	9		1.00
	TOTALS		0	849,600			
	D - DRUGS SOLD TO PATIENTS						
1.00	PHARMACY	15.00	0	643,415	0		1.00
	TOTALS		0	643,415			
	E - RENAL RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	113,400	0		1.00
	TOTALS		0	113,400			
	F - RECLASS INTEREST EXPENSE ON LEASES						
1.00	ADMINISTRATIVE & GENERAL	5.50	0	11,989	11		1.00
	TOTALS		0	11,989			
	G - RECLASS SUBSIDIARY COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.50	101,661	0	0		1.00
	TOTALS		101,661	0			
	H - RECLASS LAUNDRY EXPENSES						
1.00	HOUSEKEEPING	9.00	0	155,767	0		1.00
	TOTALS		0	155,767			
	I - RECLASS CLINIC DIRECTOR COSTS						
1.00	CLINIC	90.00	44,352	0	0		1.00
	TOTALS		44,352	0			
	J - RECLASS IMPLANT COSTS						
1.00	MEDICAL SUPPLIES CHRGED TO PATIENTS	71.00	0	128,393	0		1.00
	TOTALS		0	128,393			
	K - RENTAL RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.50	0	600,000	14		1.00
	TOTALS		0	600,000			
500.00	Grand Total: Decreases		227,045	3,837,872			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet A-7 Part I | Date/Time Prepared: 5/7/2014 3:38 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	453,943	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	1,898,129	99,218	0	99,218	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	11,059,093	888,031	0	888,031	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	13,411,165	987,249	0	987,249	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	13,411,165	987,249	0	987,249	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	453,943	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	1,997,347	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	11,947,124	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	14,398,414	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	14,398,414	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet A-7 Part II | Date/Time Prepared: 5/7/2014 3:38 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	849,600	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	849,600	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	849,600		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	849,600		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet A-7 Part III Date/Time Prepared: 5/7/2014 3:38 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	2,451,290	0	2,451,290	0.170247	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,947,124	0	11,947,124	0.829753	0	2.00
3.00	Total (sum of lines 1-2)	14,398,414	0	14,398,414	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	-596,155	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	718,155	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	122,000	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	600,000	3,845	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,912	0	0	0	720,067	2.00
3.00	Total (sum of lines 1-2)	1,912	0	0	600,000	723,912	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet A-8 | Date/Time Prepared: 5/7/2014 3:38 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)	B	-77	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,801,856			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	-664,407			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-36,101	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-4,377	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-12,265	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-2,497	ADMINISTRATIVE & GENERAL	5.50	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-4,514	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-177,122	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OFFSET SUPPORT SVCS COSTS	A	-128,810	ADULTS & PEDIATRICS	30.00	0	33.00
34.00	OFFSET CABLE TV COSTS	A	-3,336	ADMINISTRATIVE & GENERAL	5.50	0	34.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet A-8 | Date/Time Prepared: 5/7/2014 3:38 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	
35.00	OFFSET DONATIONS	A	-14,625	ADMINISTRATIVE & GENERAL	5.50	0	35.00
36.00	LOBBY PORTION OF DUES OFFSET	A	-14,904	ADMINISTRATIVE & GENERAL	5.50	0	36.00
37.00	OFFSET MISCELLANEOUS INCOME	B	-22,216	ADMINISTRATIVE & GENERAL	5.50	0	37.00
38.00	OFFSET MARKETING COSTS/LOPEZ	A	-60,000	ADMINISTRATIVE & GENERAL	5.50	0	38.00
39.00	OFFSET CLINIC RENT EXPENSE	A	-24,050	CAP REL COSTS-BLDG & FIXT	1.00	9	39.00
40.00	OFFSET CLINIC PHYS MALP COST	A	-82,539	ADMINISTRATIVE & GENERAL	5.50	0	40.00
41.00	OFFSET MISC AG EXPENSES	A	-148,217	ADMINISTRATIVE & GENERAL	5.50	0	41.00
42.00			0		0.00	0	42.00
43.00			0		0.00	0	43.00
43.01	OFFSET DENTIST COSTS	A	-754	ADMINISTRATIVE & GENERAL	5.50	0	43.01
43.05	OFFSET PHYS BILLING COSTS--ANES	A	-18,509	ANESTHESIOLOGY	53.00	0	43.05
43.06	OFFSET PHYS BILLING COSTS--ERD	A	-5,336	EMERGENCY	91.00	0	43.06
43.07	OFFSET CONSULTING MD EXPENSE	A	-23,130	ADMINISTRATIVE & GENERAL	5.50	0	43.07
44.00	OFFSET PHYS BILLING COSTS--GOLD	A	-95,677	CLINIC	90.00	0	44.00
45.00	OFFSET ER PHYS MALP COST	A	-82,500	ADMINISTRATIVE & GENERAL	5.50	0	45.00
46.00	OFFSET NONALLOWABLE COSTS	A	-36,819	ADMINISTRATIVE & GENERAL	5.50	0	46.00
46.01	OFFSET DIRECT TV	A	-3,841	ADMINISTRATIVE & GENERAL	5.50	0	46.01
46.02	OFFSET OTHER ADMN	A	-2,000	ADMINISTRATIVE & GENERAL	5.50	0	46.02
46.03	OFFSET A & G PHYSICIAN FEES	A	-92,036	ADMINISTRATIVE & GENERAL	5.50	0	46.03
47.00	INTEREST EXP NOT RELATED TO PT CARE	A	-10,000	CAP REL COSTS-MVBLE EQUIP	2.00	11	47.00
48.00			0		0.00	0	48.00
48.01	LEGAL FEES	A	-257,614	ADMINISTRATIVE & GENERAL	5.50	0	48.01
48.02	ADD EXPENSES FROM 7/1/13-7/20/13	A	45,677	CAP REL COSTS-MVBLE EQUIP	2.00	9	48.02
48.03	ADD EXPENSES FROM 7/1/13-7/20/13	A	24,321	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	48.03
48.04	ADD EXPENSES FROM 7/1/13-7/20/13	A	6,723	NONPATIENT TELEPHONES	5.10	0	48.04
48.05	ADD EXPENSES FROM 7/1/13-7/20/13	A	21,206	DATA PROCESSING	5.20	0	48.05
48.06	ADD EXPENSES FROM 7/1/13-7/20/13	A	4,333	PURCHASING	5.30	0	48.06
48.07	ADD EXPENSES FROM 7/1/13-7/20/13	A	19,005	CASHIERING	5.40	0	48.07
48.08	ADD EXPENSES FROM 7/1/13-7/20/13	A	74,870	ADMINISTRATIVE & GENERAL	5.50	0	48.08
48.09	ADD EXPENSES FROM 7/1/13-7/20/13	A	10,540	MAINTENANCE & REPAIRS	6.00	0	48.09
48.10	ADD EXPENSES FROM 7/1/13-7/20/13	A	78,927	OPERATION OF PLANT	7.00	0	48.10
48.11	ADD EXPENSES FROM 7/1/13-7/20/13	A	5,358	HOUSEKEEPING	9.00	0	48.11
48.12	ADD EXPENSES FROM 7/1/13-7/20/13	A	7,597	DIETARY	10.00	0	48.12
48.13	ADD EXPENSES FROM 7/1/13-7/20/13	A	8,501	NURSING ADMINISTRATION	13.00	0	48.13
48.14	ADD EXPENSES FROM 7/1/13-7/20/13	A	1,495	CENTRAL SERVICES & SUPPLY	14.00	0	48.14
48.15	ADD EXPENSES FROM 7/1/13-7/20/13	A	11,021	PHARMACY	15.00	0	48.15
48.16	ADD EXPENSES FROM 7/1/13-7/20/13	A	17,691	MEDICAL RECORDS & LIBRARY	16.00	0	48.16
48.17	ADD EXPENSES FROM 7/1/13-7/20/13	A	248	ADULTS & PEDIATRICS	30.00	0	48.17
48.18	ADD EXPENSES FROM 7/1/13-7/20/13	A	397	ANESTHESIOLOGY	53.00	0	48.18
48.19	ADD EXPENSES FROM 7/1/13-7/20/13	A	10,006	RADIOLOGY-DIAGNOSTIC	54.00	0	48.19
48.20	ADD EXPENSES FROM 7/1/13-7/20/13	A	2,928	LABORATORY	60.00	0	48.20
48.21	ADD EXPENSES FROM 7/1/13-7/20/13	A	709	RESPIRATORY THERAPY	65.00	0	48.21
48.22	ADD EXPENSES FROM 7/1/13-7/20/13	A	7,269	CLINIC	90.00	0	48.22
48.23	ADD EXPENSES FROM 7/1/13-7/20/13	A	894	EMERGENCY	91.00	0	48.23

ADJUSTMENTS TO EXPENSES | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet A-8 | Date/Time Prepared: 5/7/2014 3:38 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	
48.24	ADD EXPENSES FROM 7/1/13-7/20/13	A	5,523	PHYSICIANS' PRIVATE OFFICES	192.00	0	48.24
48.25	OFFSET OTHER OP REV 7/1-7/2013	A	-567	ADMINISTRATIVE & GENERAL	5.50	0	48.25
48.26			0		0.00	0	48.26
48.27			0		0.00	0	48.27
48.28			0		0.00	0	48.28
48.29			0		0.00	0	48.29
48.30			0		0.00	0	48.30
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,465,457				50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet A-8-1 | Date/Time Prepared: 5/7/2014 3:38 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	DEPRECIATION	32,409	600,000	1.00
2.00	5.50	ADMINISTRATIVE & GENERAL	LICENSE & PERMITS	6,259	0	2.00
3.00	74.00	RENAL DIALYSIS	RENAL DIALYSIS SERVICES	10,325	113,400	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			48,993	713,400	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		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	B	WESTSIDE PARTNERSHIP	100.00		0.00	6.00
7.00	B	GARFIELD KIDNEY	100.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 140151	Period: From 07/01/2012 To 07/20/2013	Worksheet A-8-1 Date/Time Prepared: 5/7/2014 3:38 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-567,591	9		1.00
2.00	6,259	0		2.00
3.00	-103,075	0		3.00
4.00	0	0		4.00
5.00	-664,407			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet A-8-2 | Date/Time Prepared: 5/7/2014 3:38 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	91.00	EMERGENCY	724,143	724,143	0	0	0	1.00
2.00	90.00	CLINIC	172,358	172,358	0	0	0	2.00
3.00	90.00	CLINIC	120,193	120,193	0	0	0	3.00
4.00	70.00	ELECTROENCEPHALOGRAPHY	47,720	47,720	0	0	0	4.00
5.00	60.00	LABORATORY	22,917	22,917	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	686,269	686,269	0	0	0	6.00
7.00	21.00	I&R SRVCES-SALARY & FRINGES APPRVD	58,000	28,256	29,744	125,000	883	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,831,600	1,801,856	29,744		883	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	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	90.00	CLINIC	0	0	0	0	0	2.00
3.00	90.00	CLINIC	0	0	0	0	0	3.00
4.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	21.00	I&R SRVCES-SALARY & FRINGES APPRVD	53,065	2,653	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			53,065	2,653	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	91.00	EMERGENCY	0	0	0	724,143		1.00
2.00	90.00	CLINIC	0	0	0	172,358		2.00
3.00	90.00	CLINIC	0	0	0	120,193		3.00
4.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	47,720		4.00
5.00	60.00	LABORATORY	0	0	0	22,917		5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	686,269		6.00
7.00	21.00	I&R SRVCES-SALARY & FRINGES APPRVD	0	53,065	0	28,256		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	53,065	0	1,801,856		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet B Part I | Date/Time Prepared: 5/7/2014 3:38 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.10	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,845	3,845				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	720,067		720,067			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,132,148	17	3,252	1,135,417		4.00
5.10	00540	NONPATIENT TELEPHONES	175,701	0	0	2,733	178,434	5.10
5.20	00550	DATA PROCESSING	364,802	0	0	13,359	2,788	5.20
5.30	00560	PURCHASING	91,814	57	10,692	7,198	3,717	5.30
5.40	00580	CASHIERING	745,437	68	12,806	54,429	7,435	5.40
5.50	00590	ADMINISTRATIVE & GENERAL	4,660,230	262	49,137	114,665	39,963	5.50
6.00	00600	MAINTENANCE & REPAIRS	316,159	0	0	13,905	5,576	6.00
7.00	00700	OPERATION OF PLANT	885,717	642	120,323	0	929	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	155,767	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	282,245	57	10,665	19,317	1,859	9.00
10.00	01000	DIETARY	525,581	153	28,621	19,254	6,505	10.00
11.00	01100	CAFETERIA	167,733	93	17,454	7,577	0	11.00
13.00	01300	NURSING ADMINISTRATION	287,955	73	13,606	18,722	2,788	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	92,270	105	19,650	7,069	3,717	14.00
15.00	01500	PHARMACY	544,968	0	0	37,883	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	313,689	173	32,374	17,558	11,152	16.00
17.00	01700	SOCIAL SERVICE	49,526	10	1,951	4,311	3,717	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	251,604	21	3,876	17,722	7,435	21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,903,237	932	174,054	247,260	13,011	30.00
31.00	03100	INTENSIVE CARE UNIT	1,063,394	104	19,555	90,796	4,647	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,015,326	304	57,024	77,981	6,505	50.00
51.00	05100	RECOVERY ROOM	123,146	23	4,350	10,718	1,859	51.00
53.00	05300	ANESTHESIOLOGY	8,376	10	1,911	8,210	2,788	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,187,833	180	33,648	67,877	7,435	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	1,387,600	117	21,953	58,238	6,505	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	562,131	34	6,450	31,665	7,435	65.00
66.00	06600	PHYSICAL THERAPY	222,885	89	16,668	18,053	2,788	66.00
69.00	06900	ELECTROCARDIOLOGY	57,931	34	6,315	4,839	3,717	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	16,360	0	0	0	0	70.00
70.50	03951	SLEEP LAB	19,410	7	1,355	1,689	0	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	1,084,113	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	128,393	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	639,038	23	4,228	0	5,576	73.00
74.00	07400	RENAL DIALYSIS	10,325	0	0	0	0	74.00
76.00	03950	INDUSTRIAL MEDICINE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	861,033	180	33,716	67,732	11,152	90.00
91.00	09100	EMERGENCY	624,366	41	7,657	51,588	7,435	91.00
92.00	09200	OBSERVATION BEDS						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,682,155	3,809	713,291	1,092,348	178,434	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	887,932	0	0	33,564	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	101,661	36	6,776	9,505	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	24,671,748	3,845	720,067	1,135,417	178,434	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet B Part I | Date/Time Prepared: 5/7/2014 3:38 pm

		Cost Center Description	DATA PROCESSING	PURCHASING	CASHIERING	Subtotal	ADMINISTRATIVE & GENERAL	
			5.20	5.30	5.40	5A.40	5.50	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.10	00540	NONPATIENT TELEPHONES						5.10
5.20	00550	DATA PROCESSING	380,949					5.20
5.30	00560	PURCHASING	0	113,478				5.30
5.40	00580	CASHIERING	190,474	761	1,011,410			5.40
5.50	00590	ADMINISTRATIVE & GENERAL	38,095	1,058	0	4,903,410	4,903,410	5.50
6.00	00600	MAINTENANCE & REPAIRS	0	1,950	0	337,590	83,737	6.00
7.00	00700	OPERATION OF PLANT	0	71	0	1,007,682	249,949	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	155,767	38,637	8.00
9.00	00900	HOUSEKEEPING	0	1,684	0	315,827	78,339	9.00
10.00	01000	DIETARY	0	9,715	0	589,829	146,304	10.00
11.00	01100	CAFETERIA	0	0	0	192,857	47,837	11.00
13.00	01300	NURSING ADMINISTRATION	0	132	0	323,276	80,187	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,546	0	127,357	31,590	14.00
15.00	01500	PHARMACY	0	22,998	0	605,849	150,277	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	38,095	271	0	413,312	102,520	16.00
17.00	01700	SOCIAL SERVICE	0	1	0	59,516	14,763	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	0	246	0	280,904	69,677	21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,877	206,889	3,549,260	880,363	30.00
31.00	03100	INTENSIVE CARE UNIT	0	923	39,713	1,219,132	302,398	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	32,170	60,813	1,250,123	310,086	50.00
51.00	05100	RECOVERY ROOM	0	205	21,611	161,912	40,161	51.00
53.00	05300	ANESTHESIOLOGY	0	1,049	58,377	80,721	20,022	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,688	98,142	1,397,803	346,717	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	21,870	150,874	1,647,157	408,567	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	3,216	56,022	666,953	165,434	65.00
66.00	06600	PHYSICAL THERAPY	0	222	9,110	269,815	66,926	66.00
69.00	06900	ELECTROCARDIOLOGY	0	96	34,981	107,913	26,767	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	5,233	21,593	5,356	70.00
70.50	03951	SLEEP LAB	0	9	3,003	25,473	6,318	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	0	0	36,521	1,120,634	277,967	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	6,427	134,820	33,441	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	137,189	786,054	194,976	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,236	11,561	2,868	74.00
76.00	03950	INDUSTRIAL MEDICINE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	76,190	1,173	29,187	1,080,363	267,978	90.00
91.00	09100	EMERGENCY	38,095	1,603	56,082	786,867	195,178	91.00
92.00	09200	OBSERVATION BEDS				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	380,949	112,534	1,011,410	23,631,330	4,645,340	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	944	0	922,440	228,806	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	117,978	29,264	194.00
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)	380,949	113,478	1,011,410	24,671,748	4,903,410	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet B Part I | Date/Time Prepared: 5/7/2014 3:38 pm

		Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.10	00540	NONPATIENT TELEPHONES						5.10
5.20	00550	DATA PROCESSING						5.20
5.30	00560	PURCHASING						5.30
5.40	00580	CASHIERING						5.40
5.50	00590	ADMINISTRATIVE & GENERAL						5.50
6.00	00600	MAINTENANCE & REPAIRS	421,327					6.00
7.00	00700	OPERATION OF PLANT	78,697	1,336,328				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	194,404			8.00
9.00	00900	HOUSEKEEPING	6,975	27,206	0	428,347		9.00
10.00	01000	DIETARY	18,719	73,009	0	23,889	851,750	10.00
11.00	01100	CAFETERIA	11,416	44,525	0	14,577	0	11.00
13.00	01300	NURSING ADMINISTRATION	8,899	34,707	0	11,361	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,852	50,125	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21,174	82,585	0	27,028	0	16.00
17.00	01700	SOCIAL SERVICE	1,276	4,978	0	1,634	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	2,535	9,887	1,943	3,242	0	21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	114,727	447,459	129,114	145,283	791,654	30.00
31.00	03100	INTENSIVE CARE UNIT	12,790	49,883	18,636	16,315	60,096	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	37,297	145,466	21,385	47,597	0	50.00
51.00	05100	RECOVERY ROOM	2,845	11,097	0	3,631	0	51.00
53.00	05300	ANESTHESIOLOGY	1,250	4,874	0	1,582	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,008	85,834	5,832	28,091	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	14,359	56,002	0	18,313	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	4,219	16,455	0	5,395	0	65.00
66.00	06600	PHYSICAL THERAPY	10,902	42,520	1,943	13,903	0	66.00
69.00	06900	ELECTROCARDIOLOGY	4,130	16,109	0	5,265	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.50	03951	SLEEP LAB	0	0	0	1,141	0	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	0	0	0	16,393	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,765	10,785	0	3,528	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	INDUSTRIAL MEDICINE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	22,052	86,007	1,943	28,143	0	90.00
91.00	09100	EMERGENCY	5,008	19,531	13,608	6,381	0	91.00
92.00	09200	OBSERVATION BEDS						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	416,895	1,319,044	194,404	422,692	851,750	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	4,432	17,284	0	5,655	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	421,327	1,336,328	194,404	428,347	851,750	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet B Part I Date/Time Prepared: 5/7/2014 3:38 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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
5.10	00540	NONPATIENT TELEPHONES						5.10
5.20	00550	DATA PROCESSING						5.20
5.30	00560	PURCHASING						5.30
5.40	00580	CASHIERING						5.40
5.50	00590	ADMINISTRATIVE & GENERAL						5.50
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	311,212					11.00
13.00	01300	NURSING ADMINISTRATION	3,827	462,257				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,388	0	225,312			14.00
15.00	01500	PHARMACY	9,525	0	0	765,651		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,013	0	0	0	653,632	16.00
17.00	01700	SOCIAL SERVICE	1,585	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	10,115	0	0	0	0	21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	91,940	201,979	0	0	258,610	30.00
31.00	03100	INTENSIVE CARE UNIT	25,051	55,042	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,618	51,873	0	0	130,666	50.00
51.00	05100	RECOVERY ROOM	1,888	4,150	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	489	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,392	0	0	0	71,794	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	23,163	0	0	0	31,590	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	11,750	25,802	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	4,029	0	0	0	24,864	66.00
69.00	06900	ELECTROCARDIOLOGY	2,276	0	0	0	11,563	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.50	03951	SLEEP LAB	556	0	0	0	0	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	0	0	199,936	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	25,376	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	765,651	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	INDUSTRIAL MEDICINE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	32,165	70,676	0	0	108,221	90.00
91.00	09100	EMERGENCY	24,006	52,735	0	0	16,324	91.00
92.00	09200	OBSERVATION BEDS						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	294,776	462,257	225,312	765,651	653,632	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	16,436	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	311,212	462,257	225,312	765,651	653,632	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet B Part I | Date/Time Prepared: 5/7/2014 3:38 pm

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS SRVCES-SALARY & FRINGES	INTERNS & RESIDENTS SRVCES-OTHER PRGM COSTS	PARAMED ED PRGM	
			17.00	19.00	21.00	22.00	23.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.10	00540	NONPATIENT TELEPHONES						5.10
5.20	00550	DATA PROCESSING						5.20
5.30	00560	PURCHASING						5.30
5.40	00580	CASHIERING						5.40
5.50	00590	ADMINISTRATIVE & GENERAL						5.50
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	83,752					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	0	0	378,303			21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0	0	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	75,377	0	42,322	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	293,832	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	15,547	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	10,710	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	5,182	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
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
70.50	03951	SLEEP LAB	0	0	0	0	0	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	INDUSTRIAL MEDICINE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8,375	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	10,710	0	0	91.00
92.00	09200	OBSERVATION BEDS						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	83,752	0	378,303	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	83,752	0	378,303	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet B Part I Date/Time Prepared: 5/7/2014 3:38 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.10	00540	NONPATIENT TELEPHONES					5.10
5.20	00550	DATA PROCESSING					5.20
5.30	00560	PURCHASING					5.30
5.40	00580	CASHIERING					5.40
5.50	00590	ADMINISTRATIVE & GENERAL					5.50
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD					21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD					22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	6,728,088	-42,322	6,685,766		30.00
31.00	03100	INTENSIVE CARE UNIT	1,759,343	0	1,759,343		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,311,943	-293,832	2,018,111		50.00
51.00	05100	RECOVERY ROOM	225,684	0	225,684		51.00
53.00	05300	ANESTHESIOLOGY	124,485	-15,547	108,938		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,987,181	-10,710	1,976,471		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
60.00	06000	LABORATORY	2,204,333	-5,182	2,199,151		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	896,008	0	896,008		65.00
66.00	06600	PHYSICAL THERAPY	434,902	0	434,902		66.00
69.00	06900	ELECTROCARDIOLOGY	174,023	0	174,023		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	26,949	0	26,949		70.00
70.50	03951	SLEEP LAB	33,488	0	33,488		70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	1,614,930	0	1,614,930		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	193,637	0	193,637		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,763,759	0	1,763,759		73.00
74.00	07400	RENAL DIALYSIS	14,429	0	14,429		74.00
76.00	03950	INDUSTRIAL MEDICINE	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1,705,923	0	1,705,923		90.00
91.00	09100	EMERGENCY	1,130,348	-10,710	1,119,638		91.00
92.00	09200	OBSERVATION BEDS		0			92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,329,453	-378,303	22,951,150		118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,167,682	0	1,167,682		192.00
194.00	07950	OTHER NONREIMBURSABLE	174,613	0	174,613		194.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	24,671,748	-378,303	24,293,445		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet B Part II Date/Time Prepared: 5/7/2014 3:38 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	17	3,252	3,269	3,269	4.00
5.10	00540	NONPATIENT TELEPHONES	0	0	0	0	8	5.10
5.20	00550	DATA PROCESSING	0	0	0	0	38	5.20
5.30	00560	PURCHASING	0	57	10,692	10,749	21	5.30
5.40	00580	CASHIERING	0	68	12,806	12,874	157	5.40
5.50	00590	ADMINISTRATIVE & GENERAL	0	262	49,137	49,399	330	5.50
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	40	6.00
7.00	00700	OPERATION OF PLANT	0	642	120,323	120,965	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	57	10,665	10,722	56	9.00
10.00	01000	DIETARY	0	153	28,621	28,774	55	10.00
11.00	01100	CAFETERIA	0	93	17,454	17,547	22	11.00
13.00	01300	NURSING ADMINISTRATION	0	73	13,606	13,679	54	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	105	19,650	19,755	20	14.00
15.00	01500	PHARMACY	0	0	0	0	109	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	173	32,374	32,547	51	16.00
17.00	01700	SOCIAL SERVICE	0	10	1,951	1,961	12	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	0	21	3,876	3,897	51	21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	932	174,054	174,986	713	30.00
31.00	03100	INTENSIVE CARE UNIT	0	104	19,555	19,659	261	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	304	57,024	57,328	224	50.00
51.00	05100	RECOVERY ROOM	0	23	4,350	4,373	31	51.00
53.00	05300	ANESTHESIOLOGY	0	10	1,911	1,921	24	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	180	33,648	33,828	195	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	117	21,953	22,070	168	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	34	6,450	6,484	91	65.00
66.00	06600	PHYSICAL THERAPY	0	89	16,668	16,757	52	66.00
69.00	06900	ELECTROCARDIOLOGY	0	34	6,315	6,349	14	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.50	03951	SLEEP LAB	0	7	1,355	1,362	5	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23	4,228	4,251	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	INDUSTRIAL MEDICINE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	180	33,716	33,896	195	90.00
91.00	09100	EMERGENCY	0	41	7,657	7,698	148	91.00
92.00	09200	OBSERVATION BEDS				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,809	713,291	717,100	3,145	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	97	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	36	6,776	6,812	27	194.00
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	3,845	720,067	723,912	3,269	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet B Part II | Date/Time Prepared: 5/7/2014 3:38 pm

		Cost Center Description	NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING	CASHIERING	ADMINISTRATIVE & GENERAL	
			5.10	5.20	5.30	5.40	5.50	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.10	00540	NONPATIENT TELEPHONES	8					5.10
5.20	00550	DATA PROCESSING	0	38				5.20
5.30	00560	PURCHASING	0	0	10,770			5.30
5.40	00580	CASHIERING	0	18	72	13,121		5.40
5.50	00590	ADMINISTRATIVE & GENERAL	5	4	100	0	49,838	5.50
6.00	00600	MAINTENANCE & REPAIRS	0	0	185	0	851	6.00
7.00	00700	OPERATION OF PLANT	0	0	7	0	2,540	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	393	8.00
9.00	00900	HOUSEKEEPING	0	0	160	0	796	9.00
10.00	01000	DIETARY	0	0	922	0	1,487	10.00
11.00	01100	CAFETERIA	0	0	0	0	486	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	13	0	815	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	431	0	321	14.00
15.00	01500	PHARMACY	0	0	2,183	0	1,527	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1	4	26	0	1,042	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	150	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	0	0	23	0	708	21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1	0	368	2,659	8,953	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	88	516	3,073	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	3,053	791	3,152	50.00
51.00	05100	RECOVERY ROOM	0	0	19	281	408	51.00
53.00	05300	ANESTHESIOLOGY	0	0	100	759	203	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	255	1,276	3,524	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	2,076	1,962	4,152	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	305	729	1,681	65.00
66.00	06600	PHYSICAL THERAPY	0	0	21	118	680	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	9	455	272	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	68	54	70.00
70.50	03951	SLEEP LAB	0	0	1	39	64	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	0	0	0	475	2,825	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	84	340	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,784	1,982	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	16	29	74.00
76.00	03950	INDUSTRIAL MEDICINE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1	8	111	380	2,724	90.00
91.00	09100	EMERGENCY	0	4	152	729	1,984	91.00
92.00	09200	OBSERVATION BEDS						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8	38	10,680	13,121	47,216	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	90	0	2,325	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	297	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	8	38	10,770	13,121	49,838	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet B Part II Date/Time Prepared: 5/7/2014 3:38 pm

		Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.10	00540	NONPATIENT TELEPHONES						5.10
5.20	00550	DATA PROCESSING						5.20
5.30	00560	PURCHASING						5.30
5.40	00580	CASHIERING						5.40
5.50	00590	ADMINISTRATIVE & GENERAL						5.50
6.00	00600	MAINTENANCE & REPAIRS	1,076					6.00
7.00	00700	OPERATION OF PLANT	201	123,713				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	393			8.00
9.00	00900	HOUSEKEEPING	18	2,519	0	14,271		9.00
10.00	01000	DIETARY	48	6,759	0	796	38,841	10.00
11.00	01100	CAFETERIA	29	4,122	0	486	0	11.00
13.00	01300	NURSING ADMINISTRATION	23	3,213	0	379	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	33	4,640	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	54	7,645	0	900	0	16.00
17.00	01700	SOCIAL SERVICE	3	461	0	54	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	6	915	4	108	0	21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	293	41,428	260	4,839	36,101	30.00
31.00	03100	INTENSIVE CARE UNIT	33	4,618	38	544	2,740	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	95	13,467	43	1,586	0	50.00
51.00	05100	RECOVERY ROOM	7	1,027	0	121	0	51.00
53.00	05300	ANESTHESIOLOGY	3	451	0	53	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	56	7,946	12	936	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	37	5,184	0	610	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	11	1,523	0	180	0	65.00
66.00	06600	PHYSICAL THERAPY	28	3,936	4	463	0	66.00
69.00	06900	ELECTROCARDIOLOGY	11	1,491	0	175	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.50	03951	SLEEP LAB	0	0	0	38	0	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	0	0	0	546	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7	998	0	118	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	INDUSTRIAL MEDICINE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	56	7,962	4	938	0	90.00
91.00	09100	EMERGENCY	13	1,808	28	213	0	91.00
92.00	09200	OBSERVATION BEDS						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,065	122,113	393	14,083	38,841	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	11	1,600	0	188	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,076	123,713	393	14,271	38,841	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet B Part II Date/Time Prepared: 5/7/2014 3:38 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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
5.10	00540	NONPATIENT TELEPHONES						5.10
5.20	00550	DATA PROCESSING						5.20
5.30	00560	PURCHASING						5.30
5.40	00580	CASHIERING						5.40
5.50	00590	ADMINISTRATIVE & GENERAL						5.50
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	22,692					11.00
13.00	01300	NURSING ADMINISTRATION	279	18,455				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	247	0	25,447			14.00
15.00	01500	PHARMACY	694	0	0	4,513		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	511	0	0	0	42,781	16.00
17.00	01700	SOCIAL SERVICE	116	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	738	0	0	0	0	21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,703	8,064	0	0	16,927	30.00
31.00	03100	INTENSIVE CARE UNIT	1,827	2,197	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,722	2,071	0	0	8,552	50.00
51.00	05100	RECOVERY ROOM	138	166	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	36	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,341	0	0	0	4,699	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	1,689	0	0	0	2,068	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	857	1,030	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	294	0	0	0	1,627	66.00
69.00	06900	ELECTROCARDIOLOGY	166	0	0	0	757	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.50	03951	SLEEP LAB	41	0	0	0	0	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	0	0	22,581	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	2,866	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,513	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	INDUSTRIAL MEDICINE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,345	2,822	0	0	7,083	90.00
91.00	09100	EMERGENCY	1,750	2,105	0	0	1,068	91.00
92.00	09200	OBSERVATION BEDS						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,494	18,455	25,447	4,513	42,781	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,198	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	22,692	18,455	25,447	4,513	42,781	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet B Part II Date/Time Prepared: 5/7/2014 3:38 pm

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS SRVCES-SALARY & FRINGES	INTERNS & RESIDENTS SRVCES-OTHER PRGM COSTS	PARAMED ED PRGM	
			17.00	19.00	21.00	22.00	23.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.10	00540	NONPATIENT TELEPHONES						5.10
5.20	00550	DATA PROCESSING						5.20
5.30	00560	PURCHASING						5.30
5.40	00580	CASHIERING						5.40
5.50	00590	ADMINISTRATIVE & GENERAL						5.50
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	2,757					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	0		6,450			21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0			0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0				0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,481					30.00
31.00	03100	INTENSIVE CARE UNIT	0					31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0					50.00
51.00	05100	RECOVERY ROOM	0					51.00
53.00	05300	ANESTHESIOLOGY	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0					54.00
56.00	05600	RADIOISOTOPE	0					56.00
60.00	06000	LABORATORY	0					60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0					62.30
65.00	06500	RESPIRATORY THERAPY	0					65.00
66.00	06600	PHYSICAL THERAPY	0					66.00
69.00	06900	ELECTROCARDIOLOGY	0					69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0					70.00
70.50	03951	SLEEP LAB	0					70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0					73.00
74.00	07400	RENAL DIALYSIS	0					74.00
76.00	03950	INDUSTRIAL MEDICINE	0					76.00
76.97	07697	CARDIAC REHABILITATION	0					76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0					76.98
76.99	07699	LITHOTRIPSY	0					76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	276					90.00
91.00	09100	EMERGENCY	0					91.00
92.00	09200	OBSERVATION BEDS						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,757	0	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0					192.00
194.00	07950	OTHER NONREIMBURSABLE	0					194.00
200.00		Cross Foot Adjustments		0	6,450	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,757	0	6,450	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet B Part II | Date/Time Prepared: 5/7/2014 3:38 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.10	00540	NONPATIENT TELEPHONES					5.10
5.20	00550	DATA PROCESSING					5.20
5.30	00560	PURCHASING					5.30
5.40	00580	CASHIERING					5.40
5.50	00590	ADMINISTRATIVE & GENERAL					5.50
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD					21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD					22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	304,776	0	304,776		30.00
31.00	03100	INTENSIVE CARE UNIT	35,594	0	35,594		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	92,084	0	92,084		50.00
51.00	05100	RECOVERY ROOM	6,571	0	6,571		51.00
53.00	05300	ANESTHESIOLOGY	3,550	0	3,550		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54,068	0	54,068		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
60.00	06000	LABORATORY	40,016	0	40,016		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	12,891	0	12,891		65.00
66.00	06600	PHYSICAL THERAPY	23,980	0	23,980		66.00
69.00	06900	ELECTROCARDIOLOGY	9,699	0	9,699		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	122	0	122		70.00
70.50	03951	SLEEP LAB	1,550	0	1,550		70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	26,427	0	26,427		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,290	0	3,290		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,653	0	13,653		73.00
74.00	07400	RENAL DIALYSIS	45	0	45		74.00
76.00	03950	INDUSTRIAL MEDICINE	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	58,801	0	58,801		90.00
91.00	09100	EMERGENCY	17,700	0	17,700		91.00
92.00	09200	OBSERVATION BEDS		0			92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	704,817	0	704,817		118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,710	0	3,710		192.00
194.00	07950	OTHER NONREIMBURSABLE	8,935	0	8,935		194.00
200.00		Cross Foot Adjustments	6,450	0	6,450		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	723,912	0	723,912		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet B-1 | Date/Time Prepared: 5/7/2014 3:38 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (TIME SPENT)	
			1.00	2.00	4.00	5.10	5.20	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	53,136					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		53,136				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	240	240	12,143,309			4.00
5.10	00540	NONPATIENT TELEPHONES	0	0	29,227	192		5.10
5.20	00550	DATA PROCESSING	0	0	142,874	3	100	5.20
5.30	00560	PURCHASING	789	789	76,982	4	0	5.30
5.40	00580	CASHIERING	945	945	582,117	8	50	5.40
5.50	00590	ADMINISTRATIVE & GENERAL	3,626	3,626	1,226,355	43	10	5.50
6.00	00600	MAINTENANCE & REPAIRS	0	0	148,717	6	0	6.00
7.00	00700	OPERATION OF PLANT	8,879	8,879	0	1	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	787	787	206,595	2	0	9.00
10.00	01000	DIETARY	2,112	2,112	205,920	7	0	10.00
11.00	01100	CAFETERIA	1,288	1,288	81,032	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,004	1,004	200,235	3	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,450	1,450	75,605	4	0	14.00
15.00	01500	PHARMACY	0	0	405,160	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,389	2,389	187,779	12	10	16.00
17.00	01700	SOCIAL SERVICE	144	144	46,103	4	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	286	286	189,539	8	0	21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,844	12,844	2,644,436	14	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,443	1,443	971,071	5	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,208	4,208	834,014	7	0	50.00
51.00	05100	RECOVERY ROOM	321	321	114,631	2	0	51.00
53.00	05300	ANESTHESIOLOGY	141	141	87,805	3	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,483	2,483	725,945	8	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	1,620	1,620	622,856	7	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	476	476	338,656	8	0	65.00
66.00	06600	PHYSICAL THERAPY	1,230	1,230	193,080	3	0	66.00
69.00	06900	ELECTROCARDIOLOGY	466	466	51,755	4	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.50	03951	SLEEP LAB	100	100	18,059	0	0	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	312	312	0	6	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	INDUSTRIAL MEDICINE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,488	2,488	724,398	12	20	90.00
91.00	09100	EMERGENCY	565	565	551,735	8	10	91.00
92.00	09200	OBSERVATION BEDS						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	52,636	52,636	11,682,681	192	100	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	358,967	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	500	500	101,661	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,845	720,067	1,135,417	178,434	380,949	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.072361	13.551396	0.093501	929.343750	3,809.490000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			3,269	8	38	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000269	0.041667	0.380000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet B-1 | Date/Time Prepared: 5/7/2014 3:38 pm

		Cost Center Description	PURCHASING (COST OF REQUISTION)	CASHIERING (GROSS REVENUE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
			5.30	5.40	5A.50	5.50	6.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.10	00540	NONPATIENT TELEPHONES						5.10
5.20	00550	DATA PROCESSING						5.20
5.30	00560	PURCHASING	3,249,242					5.30
5.40	00580	CASHIERING	21,777	70,717,970				5.40
5.50	00590	ADMINISTRATIVE & GENERAL	30,298	0	-4,903,410	19,768,338		5.50
6.00	00600	MAINTENANCE & REPAIRS	55,839	0	0	337,590	47,536	6.00
7.00	00700	OPERATION OF PLANT	2,034	0	0	1,007,682	8,879	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	155,767	0	8.00
9.00	00900	HOUSEKEEPING	48,228	0	0	315,827	787	9.00
10.00	01000	DIETARY	278,186	0	0	589,829	2,112	10.00
11.00	01100	CAFETERIA	0	0	0	192,857	1,288	11.00
13.00	01300	NURSING ADMINISTRATION	3,782	0	0	323,276	1,004	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	130,156	0	0	127,357	1,450	14.00
15.00	01500	PHARMACY	658,512	0	0	605,849	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,756	0	0	413,312	2,389	16.00
17.00	01700	SOCIAL SERVICE	39	0	0	59,516	144	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	7,047	0	0	280,904	286	21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	110,999	14,465,715	0	3,549,260	12,944	30.00
31.00	03100	INTENSIVE CARE UNIT	26,427	2,776,722	0	1,219,132	1,443	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	921,118	4,252,037	0	1,250,123	4,208	50.00
51.00	05100	RECOVERY ROOM	5,863	1,511,016	0	161,912	321	51.00
53.00	05300	ANESTHESIOLOGY	30,047	4,081,703	0	80,721	141	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	76,956	6,862,126	0	1,397,803	2,483	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	626,214	10,549,134	0	1,647,157	1,620	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	92,078	3,917,078	0	666,953	476	65.00
66.00	06600	PHYSICAL THERAPY	6,347	636,979	0	269,815	1,230	66.00
69.00	06900	ELECTROCARDIOLOGY	2,763	2,445,864	0	107,913	466	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	365,864	0	21,593	0	70.00
70.50	03951	SLEEP LAB	269	209,954	0	25,473	0	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	0	2,553,565	0	1,120,634	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	449,375	0	134,820	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,592,309	0	786,054	312	73.00
74.00	07400	RENAL DIALYSIS	0	86,451	0	11,561	0	74.00
76.00	03950	INDUSTRIAL MEDICINE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	33,576	2,040,783	0	1,080,363	2,488	90.00
91.00	09100	EMERGENCY	45,896	3,921,295	0	786,867	565	91.00
92.00	09200	OBSERVATION BEDS						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,222,207	70,717,970	-4,903,410	18,727,920	47,036	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	27,035	0	0	922,440	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	117,978	500	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	113,478	1,011,410		4,903,410	421,327	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.034924	0.014302		0.248044	8.863325	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	10,770	13,121		49,838	1,076	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.003315	0.000186		0.002521	0.022635	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet B-1 | Date/Time Prepared: 5/7/2014 3:38 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.10	00540	NONPATIENT TELEPHONES						5.10
5.20	00550	DATA PROCESSING						5.20
5.30	00560	PURCHASING						5.30
5.40	00580	CASHIERING						5.40
5.50	00590	ADMINISTRATIVE & GENERAL						5.50
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	38,657					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	175,369				8.00
9.00	00900	HOUSEKEEPING	787	0	16,514			9.00
10.00	01000	DIETARY	2,112	0	921	34,696		10.00
11.00	01100	CAFETERIA	1,288	0	562	0	18,461	11.00
13.00	01300	NURSING ADMINISTRATION	1,004	0	438	0	227	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,450	0	0	0	201	14.00
15.00	01500	PHARMACY	0	0	0	0	565	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,389	0	1,042	0	416	16.00
17.00	01700	SOCIAL SERVICE	144	0	63	0	94	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	286	1,753	125	0	600	21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,944	116,471	5,601	32,248	5,454	30.00
31.00	03100	INTENSIVE CARE UNIT	1,443	16,811	629	2,448	1,486	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,208	19,291	1,835	0	1,401	50.00
51.00	05100	RECOVERY ROOM	321	0	140	0	112	51.00
53.00	05300	ANESTHESIOLOGY	141	0	61	0	29	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,483	5,261	1,083	0	1,091	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	1,620	0	706	0	1,374	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	476	0	208	0	697	65.00
66.00	06600	PHYSICAL THERAPY	1,230	1,753	536	0	239	66.00
69.00	06900	ELECTROCARDIOLOGY	466	0	203	0	135	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.50	03951	SLEEP LAB	0	0	44	0	33	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	0	0	632	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	312	0	136	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	INDUSTRIAL MEDICINE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,488	1,753	1,085	0	1,908	90.00
91.00	09100	EMERGENCY	565	12,276	246	0	1,424	91.00
92.00	09200	OBSERVATION BEDS						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	38,157	175,369	16,296	34,696	17,486	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	975	192.00
194.00	07950	OTHER NONREIMBURSABLE	500	0	218	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,336,328	194,404	428,347	851,750	311,212	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	34.568849	1.108543	25.938416	24.548939	16.857808	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	123,713	393	14,271	38,841	22,692	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.200274	0.002241	0.864176	1.119466	1.229186	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet B-1 | Date/Time Prepared: 5/7/2014 3:38 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.10	00540	NONPATIENT TELEPHONES						5.10
5.20	00550	DATA PROCESSING						5.20
5.30	00560	PURCHASING						5.30
5.40	00580	CASHIERING						5.40
5.50	00590	ADMINISTRATIVE & GENERAL						5.50
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	259,614					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,366,398				14.00
15.00	01500	PHARMACY	0	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	8,649		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	100	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	113,436	0	0	3,422	90	30.00
31.00	03100	INTENSIVE CARE UNIT	30,913	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,133	0	0	1,729	0	50.00
51.00	05100	RECOVERY ROOM	2,331	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	950	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	418	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	14,491	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	329	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	153	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.50	03951	SLEEP LAB	0	0	0	0	0	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	0	1,212,506	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	153,892	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	INDUSTRIAL MEDICINE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	39,693	0	0	1,432	10	90.00
91.00	09100	EMERGENCY	29,617	0	0	216	0	91.00
92.00	09200	OBSERVATION BEDS						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	259,614	1,366,398	100	8,649	100	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	462,257	225,312	765,651	653,632	83,752	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.780555	0.164895	7,656.510000	75.573130	837.520000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	18,455	25,447	4,513	42,781	2,757	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.071086	0.018623	45.130000	4.946352	27.570000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet B-1 | Date/Time Prepared: 5/7/2014 3:38 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	INTERNS & RESIDENTS SRVCES-SALARY & FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS SRVCES-OTHER PRGM COSTS (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)		
			19.00	21.00	22.00	23.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.10	00540	NONPATIENT TELEPHONES						5.10
5.20	00550	DATA PROCESSING						5.20
5.30	00560	PURCHASING						5.30
5.40	00580	CASHIERING						5.40
5.50	00590	ADMINISTRATIVE & GENERAL						5.50
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD		2,190				21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD			0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)				0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		245	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,701	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	90	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	62	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
60.00	06000	LABORATORY	0	30	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
70.50	03951	SLEEP LAB	0	0	0	0		70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0		74.00
76.00	03950	INDUSTRIAL MEDICINE	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	62	0	0		91.00
92.00	09200	OBSERVATION BEDS						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,190	0	0		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0		194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	378,303	0	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	172.741096	0.000000	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	6,450	0	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	2.945205	0.000000	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet C Part I Date/Time Prepared: 5/7/2014 3:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,685,766		6,685,766	0	6,685,766	30.00
31.00	03100	INTENSIVE CARE UNIT	1,759,343		1,759,343	0	1,759,343	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,018,111		2,018,111	0	2,018,111	50.00
51.00	05100	RECOVERY ROOM	225,684		225,684	0	225,684	51.00
53.00	05300	ANESTHESIOLOGY	108,938		108,938	0	108,938	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,976,471		1,976,471	0	1,976,471	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
60.00	06000	LABORATORY	2,199,151		2,199,151	0	2,199,151	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	896,008	0	896,008	0	896,008	65.00
66.00	06600	PHYSICAL THERAPY	434,902	0	434,902	0	434,902	66.00
69.00	06900	ELECTROCARDIOLOGY	174,023		174,023	0	174,023	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	26,949		26,949	0	26,949	70.00
70.50	03951	SLEEP LAB	33,488		33,488	0	33,488	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	1,614,930		1,614,930	0	1,614,930	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	193,637		193,637	0	193,637	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,763,759		1,763,759	0	1,763,759	73.00
74.00	07400	RENAL DIALYSIS	14,429		14,429	0	14,429	74.00
76.00	03950	INDUSTRIAL MEDICINE	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,705,923		1,705,923	0	1,705,923	90.00
91.00	09100	EMERGENCY	1,119,638		1,119,638	0	1,119,638	91.00
92.00	09200	OBSERVATION BEDS	188,941		188,941		188,941	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	23,140,091	0	23,140,091	0	23,140,091	200.00
201.00		Less Observation Beds	188,941		188,941		188,941	201.00
202.00		Total (see instructions)	22,951,150	0	22,951,150	0	22,951,150	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet C Part I Date/Time Prepared: 5/7/2014 3:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,962,725		13,962,725			30.00
31.00	03100	INTENSIVE CARE UNIT	2,776,722		2,776,722			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,562,031	2,690,006	4,252,037	0.474622	0.000000	50.00
51.00	05100	RECOVERY ROOM	464,904	1,046,112	1,511,016	0.149359	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	1,726,793	2,354,910	4,081,703	0.026689	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,423,033	4,439,093	6,862,126	0.288026	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
60.00	06000	LABORATORY	5,361,418	5,187,716	10,549,134	0.208467	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	3,662,702	254,376	3,917,078	0.228744	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	404,932	232,047	636,979	0.682757	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	1,355,053	1,090,811	2,445,864	0.071150	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	147,328	218,536	365,864	0.073659	0.000000	70.00
70.50	03951	SLEEP LAB	2,594	207,360	209,954	0.159502	0.000000	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	1,441,585	1,111,980	2,553,565	0.632422	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	356,420	92,955	449,375	0.430903	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,162,872	1,429,437	9,592,309	0.183872	0.000000	73.00
74.00	07400	RENAL DIALYSIS	86,451	0	86,451	0.166904	0.000000	74.00
76.00	03950	INDUSTRIAL MEDICINE	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	14,477	2,026,306	2,040,783	0.835916	0.000000	90.00
91.00	09100	EMERGENCY	432,036	3,489,259	3,921,295	0.285528	0.000000	91.00
92.00	09200	OBSERVATION BEDS	0	502,990	502,990	0.375636	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	44,344,076	26,373,894	70,717,970			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	44,344,076	26,373,894	70,717,970			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet C Part I Date/Time Prepared: 5/7/2014 3:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.474622	50.00
51.00	05100	RECOVERY ROOM	0.149359	51.00
53.00	05300	ANESTHESIOLOGY	0.026689	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.288026	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
60.00	06000	LABORATORY	0.208467	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0.228744	65.00
66.00	06600	PHYSICAL THERAPY	0.682757	66.00
69.00	06900	ELECTROCARDIOLOGY	0.071150	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.073659	70.00
70.50	03951	SLEEP LAB	0.159502	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	0.632422	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.430903	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.183872	73.00
74.00	07400	RENAL DIALYSIS	0.166904	74.00
76.00	03950	INDUSTRIAL MEDICINE	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
76.99	07699	LITHOTRIPSY	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.835916	90.00
91.00	09100	EMERGENCY	0.285528	91.00
92.00	09200	OBSERVATION BEDS	0.375636	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: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet C Part I Date/Time Prepared: 5/7/2014 3:38 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,685,766		6,685,766	0	6,685,766	30.00
31.00	03100	INTENSIVE CARE UNIT	1,759,343		1,759,343	0	1,759,343	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,018,111		2,018,111	0	2,018,111	50.00
51.00	05100	RECOVERY ROOM	225,684		225,684	0	225,684	51.00
53.00	05300	ANESTHESIOLOGY	108,938		108,938	0	108,938	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,976,471		1,976,471	0	1,976,471	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
60.00	06000	LABORATORY	2,199,151		2,199,151	0	2,199,151	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	896,008	0	896,008	0	896,008	65.00
66.00	06600	PHYSICAL THERAPY	434,902	0	434,902	0	434,902	66.00
69.00	06900	ELECTROCARDIOLOGY	174,023		174,023	0	174,023	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	26,949		26,949	0	26,949	70.00
70.50	03951	SLEEP LAB	33,488		33,488	0	33,488	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	1,614,930		1,614,930	0	1,614,930	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	193,637		193,637	0	193,637	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,763,759		1,763,759	0	1,763,759	73.00
74.00	07400	RENAL DIALYSIS	14,429		14,429	0	14,429	74.00
76.00	03950	INDUSTRIAL MEDICINE	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,705,923		1,705,923	0	1,705,923	90.00
91.00	09100	EMERGENCY	1,119,638		1,119,638	0	1,119,638	91.00
92.00	09200	OBSERVATION BEDS	188,941		188,941		188,941	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	23,140,091	0	23,140,091	0	23,140,091	200.00
201.00		Less Observation Beds	188,941		188,941		188,941	201.00
202.00		Total (see instructions)	22,951,150	0	22,951,150	0	22,951,150	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet C Part I Date/Time Prepared: 5/7/2014 3:38 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,962,725		13,962,725			30.00
31.00	03100	INTENSIVE CARE UNIT	2,776,722		2,776,722			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,562,031	2,690,006	4,252,037	0.474622	0.000000	50.00
51.00	05100	RECOVERY ROOM	464,904	1,046,112	1,511,016	0.149359	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	1,726,793	2,354,910	4,081,703	0.026689	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,423,033	4,439,093	6,862,126	0.288026	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
60.00	06000	LABORATORY	5,361,418	5,187,716	10,549,134	0.208467	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	3,662,702	254,376	3,917,078	0.228744	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	404,932	232,047	636,979	0.682757	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	1,355,053	1,090,811	2,445,864	0.071150	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	147,328	218,536	365,864	0.073659	0.000000	70.00
70.50	03951	SLEEP LAB	2,594	207,360	209,954	0.159502	0.000000	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	1,441,585	1,111,980	2,553,565	0.632422	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	356,420	92,955	449,375	0.430903	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,162,872	1,429,437	9,592,309	0.183872	0.000000	73.00
74.00	07400	RENAL DIALYSIS	86,451	0	86,451	0.166904	0.000000	74.00
76.00	03950	INDUSTRIAL MEDICINE	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	14,477	2,026,306	2,040,783	0.835916	0.000000	90.00
91.00	09100	EMERGENCY	432,036	3,489,259	3,921,295	0.285528	0.000000	91.00
92.00	09200	OBSERVATION BEDS	0	502,990	502,990	0.375636	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	44,344,076	26,373,894	70,717,970			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	44,344,076	26,373,894	70,717,970			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet C Part I Date/Time Prepared: 5/7/2014 3:38 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.474622	50.00
51.00	05100	RECOVERY ROOM	0.149359	51.00
53.00	05300	ANESTHESIOLOGY	0.026689	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.288026	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
60.00	06000	LABORATORY	0.208467	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0.228744	65.00
66.00	06600	PHYSICAL THERAPY	0.682757	66.00
69.00	06900	ELECTROCARDIOLOGY	0.071150	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.073659	70.00
70.50	03951	SLEEP LAB	0.159502	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	0.632422	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.430903	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.183872	73.00
74.00	07400	RENAL DIALYSIS	0.166904	74.00
76.00	03950	INDUSTRIAL MEDICINE	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
76.99	07699	LITHOTRIPSY	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.835916	90.00
91.00	09100	EMERGENCY	0.285528	91.00
92.00	09200	OBSERVATION BEDS	0.375636	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

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet C Part II Date/Time Prepared: 5/7/2014 3:38 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,018,111	92,084	1,926,027	0	0	50.00
51.00	05100	RECOVERY ROOM	225,684	6,571	219,113	0	0	51.00
53.00	05300	ANESTHESIOLOGY	108,938	3,550	105,388	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,976,471	54,068	1,922,403	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	2,199,151	40,016	2,159,135	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	896,008	12,891	883,117	0	0	65.00
66.00	06600	PHYSICAL THERAPY	434,902	23,980	410,922	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	174,023	9,699	164,324	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	26,949	122	26,827	0	0	70.00
70.50	03951	SLEEP LAB	33,488	1,550	31,938	0	0	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	1,614,930	26,427	1,588,503	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	193,637	3,290	190,347	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,763,759	13,653	1,750,106	0	0	73.00
74.00	07400	RENAL DIALYSIS	14,429	45	14,384	0	0	74.00
76.00	03950	INDUSTRIAL MEDICINE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,705,923	58,801	1,647,122	0	0	90.00
91.00	09100	EMERGENCY	1,119,638	17,700	1,101,938	0	0	91.00
92.00	09200	OBSERVATION BEDS	188,941	8,613	180,328	0	0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	14,694,982	373,060	14,321,922	0	0	200.00
201.00		Less Observation Beds	188,941	8,613	180,328	0	0	201.00
202.00		Total (line 200 minus line 201)	14,506,041	364,447	14,141,594	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet C Part II Date/Time Prepared: 5/7/2014 3:38 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,018,111	4,252,037	0.474622		50.00
51.00	05100	RECOVERY ROOM	225,684	1,511,016	0.149359		51.00
53.00	05300	ANESTHESIOLOGY	108,938	4,081,703	0.026689		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,976,471	6,862,126	0.288026		54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000		56.00
60.00	06000	LABORATORY	2,199,151	10,549,134	0.208467		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	896,008	3,917,078	0.228744		65.00
66.00	06600	PHYSICAL THERAPY	434,902	636,979	0.682757		66.00
69.00	06900	ELECTROCARDIOLOGY	174,023	2,445,864	0.071150		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	26,949	365,864	0.073659		70.00
70.50	03951	SLEEP LAB	33,488	209,954	0.159502		70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	1,614,930	2,553,565	0.632422		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	193,637	449,375	0.430903		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,763,759	9,592,309	0.183872		73.00
74.00	07400	RENAL DIALYSIS	14,429	86,451	0.166904		74.00
76.00	03950	INDUSTRIAL MEDICINE	0	0	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000		76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000		76.99
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1,705,923	2,040,783	0.835916		90.00
91.00	09100	EMERGENCY	1,119,638	3,921,295	0.285528		91.00
92.00	09200	OBSERVATION BEDS	188,941	502,990	0.375636		92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	14,694,982	53,978,523			200.00
201.00		Less Observation Beds	188,941	0			201.00
202.00		Total (line 200 minus line 201)	14,506,041	53,978,523			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet D Part I Date/Time Prepared: 5/7/2014 3:38 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	304,776	0	304,776	11,748	25.94	30.00
31.00	INTENSIVE CARE UNIT	35,594		35,594	1,632	21.81	31.00
200.00	Total (lines 30-199)	340,370		340,370	13,380		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	6,451	167,339	30.00
31.00	INTENSIVE CARE UNIT	1,040	22,682	31.00
200.00	Total (lines 30-199)	7,491	190,021	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet D Part II Date/Time Prepared: 5/7/2014 3:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	92,084	4,252,037	0.021656	1,173,867	25,421	50.00
51.00	05100	RECOVERY ROOM	6,571	1,511,016	0.004349	281,423	1,224	51.00
53.00	05300	ANESTHESIOLOGY	3,550	4,081,703	0.000870	1,057,014	920	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54,068	6,862,126	0.007879	1,751,583	13,801	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
60.00	06000	LABORATORY	40,016	10,549,134	0.003793	3,876,712	14,704	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	12,891	3,917,078	0.003291	1,603,291	5,276	65.00
66.00	06600	PHYSICAL THERAPY	23,980	636,979	0.037646	264,022	9,939	66.00
69.00	06900	ELECTROCARDIOLOGY	9,699	2,445,864	0.003965	873,229	3,462	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	122	365,864	0.000333	70,356	23	70.00
70.50	03951	SLEEP LAB	1,550	209,954	0.007383	0	0	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	26,427	2,553,565	0.010349	1,136,455	11,761	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,290	449,375	0.007321	338,520	2,478	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,653	9,592,309	0.001423	4,557,399	6,485	73.00
74.00	07400	RENAL DIALYSIS	45	86,451	0.000521	68,251	36	74.00
76.00	03950	INDUSTRIAL MEDICINE	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	58,801	2,040,783	0.028813	10,812	312	90.00
91.00	09100	EMERGENCY	17,700	3,921,295	0.004514	345,982	1,562	91.00
92.00	09200	OBSERVATION BEDS	8,613	502,990	0.017124	0	0	92.00
200.00		Total (lines 50-199)	373,060	53,978,523		17,408,916	97,404	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet D Part III Date/Time Prepared: 5/7/2014 3:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
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)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,748	0.00	6,451	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,632	0.00	1,040	0		31.00
200.00		Total (lines 30-199)	13,380		7,491	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet D Part IV | Date/Time Prepared: 5/7/2014 3:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
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
70.50	03951	SLEEP LAB	0	0	0	0	0	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	INDUSTRIAL MEDICINE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS	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: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet D Part IV Date/Time Prepared: 5/7/2014 3:38 pm

Title XVIII | Hospital | PPS

		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	4,252,037	0.000000	0.000000	1,173,867	50.00
51.00	05100	RECOVERY ROOM	0	1,511,016	0.000000	0.000000	281,423	51.00
53.00	05300	ANESTHESIOLOGY	0	4,081,703	0.000000	0.000000	1,057,014	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,862,126	0.000000	0.000000	1,751,583	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
60.00	06000	LABORATORY	0	10,549,134	0.000000	0.000000	3,876,712	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	3,917,078	0.000000	0.000000	1,603,291	65.00
66.00	06600	PHYSICAL THERAPY	0	636,979	0.000000	0.000000	264,022	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,445,864	0.000000	0.000000	873,229	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	365,864	0.000000	0.000000	70,356	70.00
70.50	03951	SLEEP LAB	0	209,954	0.000000	0.000000	0	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	0	2,553,565	0.000000	0.000000	1,136,455	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	449,375	0.000000	0.000000	338,520	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,592,309	0.000000	0.000000	4,557,399	73.00
74.00	07400	RENAL DIALYSIS	0	86,451	0.000000	0.000000	68,251	74.00
76.00	03950	INDUSTRIAL MEDICINE	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0.000000	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,040,783	0.000000	0.000000	10,812	90.00
91.00	09100	EMERGENCY	0	3,921,295	0.000000	0.000000	345,982	91.00
92.00	09200	OBSERVATION BEDS	0	502,990	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	53,978,523			17,408,916	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet D Part IV | Date/Time Prepared: 5/7/2014 3:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 1/1	Outpatient Program Charges on/after 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 1/1	
			11.00	12.00	12.01	13.00	13.01	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,147,392	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	551,407	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	1,130,154	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,147,619	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	171,358	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	43,163	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	83,323	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	548,797	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	42,328	0	0	0	70.00
70.50	03951	SLEEP LAB	0	0	0	0	0	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	0	655,574	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	52,478	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	618,664	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	INDUSTRIAL MEDICINE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,476,279	0	0	0	90.00
91.00	09100	EMERGENCY	0	335,435	0	0	0	91.00
92.00	09200	OBSERVATION BEDS	0	241,584	0	0	0	92.00
200.00		Total (lines 50-199)	0	9,245,555	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet D Part V Date/Time Prepared: 5/7/2014 3:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.) before 1/1	Charges: PPS Reimbursed Services (see inst.) on/after 1/1	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			1.00	2.00	2.01	3.00	4.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.474622	1,147,392	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.149359	551,407	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.026689	1,130,154	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.288026	2,147,619	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY	0.208467	171,358	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.228744	43,163	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.682757	83,323	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.071150	548,797	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.073659	42,328	0	0	0	70.00
70.50	03951	SLEEP LAB	0.159502	0	0	0	0	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	0.632422	655,574	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.430903	52,478	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.183872	618,664	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.166904	0	0	0	0	74.00
76.00	03950	INDUSTRIAL MEDICINE	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.835916	1,476,279	0	0	0	90.00
91.00	09100	EMERGENCY	0.285528	335,435	0	11	0	91.00
92.00	09200	OBSERVATION BEDS	0.375636	241,584	0	0	0	92.00
200.00		Subtotal (see instructions)		9,245,555	0	11	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		9,245,555	0	11	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet D Part V Date/Time Prepared: 5/7/2014 3:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs					
			PPS Services (see inst.) before 1/1	PPS Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			5.00	5.01	6.00	7.00		
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	544,577	0	0	0		50.00
51.00	05100	RECOVERY ROOM	82,358	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	30,163	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	618,570	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
60.00	06000	LABORATORY	35,722	0	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	9,873	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	56,889	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	39,047	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,118	0	0	0		70.00
70.50	03951	SLEEP LAB	0	0	0	0		70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	414,599	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	22,613	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	113,755	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0		74.00
76.00	03950	INDUSTRIAL MEDICINE	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,234,045	0	0	0		90.00
91.00	09100	EMERGENCY	95,776	0	3	0		91.00
92.00	09200	OBSERVATION BEDS	90,748	0	0	0		92.00
200.00		Subtotal (see instructions)	3,391,853	0	3	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0			201.00
202.00		Net Charges (line 200 +/- line 201)	3,391,853	0	3	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet D Part I Date/Time Prepared: 5/7/2014 3:38 pm

Title XIX | 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	304,776	0	304,776	11,748	25.94	30.00
31.00	INTENSIVE CARE UNIT	35,594		35,594	1,632	21.81	31.00
200.00	Total (lines 30-199)	340,370		340,370	13,380		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	3,194	82,852				30.00
31.00	INTENSIVE CARE UNIT	416	9,073				31.00
200.00	Total (lines 30-199)	3,610	91,925				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet D Part II Date/Time Prepared: 5/7/2014 3:38 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	92,084	4,252,037	0.021656	0	0	50.00
51.00	05100	RECOVERY ROOM	6,571	1,511,016	0.004349	0	0	51.00
53.00	05300	ANESTHESIOLOGY	3,550	4,081,703	0.000870	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54,068	6,862,126	0.007879	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
60.00	06000	LABORATORY	40,016	10,549,134	0.003793	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	12,891	3,917,078	0.003291	0	0	65.00
66.00	06600	PHYSICAL THERAPY	23,980	636,979	0.037646	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	9,699	2,445,864	0.003965	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	122	365,864	0.000333	0	0	70.00
70.50	03951	SLEEP LAB	1,550	209,954	0.007383	0	0	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	26,427	2,553,565	0.010349	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,290	449,375	0.007321	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,653	9,592,309	0.001423	0	0	73.00
74.00	07400	RENAL DIALYSIS	45	86,451	0.000521	0	0	74.00
76.00	03950	INDUSTRIAL MEDICINE	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	58,801	2,040,783	0.028813	0	0	90.00
91.00	09100	EMERGENCY	17,700	3,921,295	0.004514	0	0	91.00
92.00	09200	OBSERVATION BEDS	8,613	502,990	0.017124	0	0	92.00
200.00		Total (lines 50-199)	373,060	53,978,523		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet D Part III Date/Time Prepared: 5/7/2014 3:38 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
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)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,748	0.00	3,194	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,632	0.00	416	0		31.00
200.00		Total (lines 30-199)	13,380		3,610	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet D Part IV | Date/Time Prepared: 5/7/2014 3:38 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
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
70.50	03951	SLEEP LAB	0	0	0	0	0	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	INDUSTRIAL MEDICINE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS	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: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet D Part IV Date/Time Prepared: 5/7/2014 3:38 pm

Title XIX | Hospital | PPS

		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	4,252,037	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	1,511,016	0.000000	0.000000	0	51.00
53.00	05300	ANESTHESIOLOGY	0	4,081,703	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,862,126	0.000000	0.000000	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
60.00	06000	LABORATORY	0	10,549,134	0.000000	0.000000	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	3,917,078	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	636,979	0.000000	0.000000	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,445,864	0.000000	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	365,864	0.000000	0.000000	0	70.00
70.50	03951	SLEEP LAB	0	209,954	0.000000	0.000000	0	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	0	2,553,565	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	449,375	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,592,309	0.000000	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	0	86,451	0.000000	0.000000	0	74.00
76.00	03950	INDUSTRIAL MEDICINE	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0.000000	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,040,783	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	3,921,295	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS	0	502,990	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	53,978,523			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet D Part IV Date/Time Prepared: 5/7/2014 3:38 pm

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 1/1	Outpatient Program Charges on/after 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 1/1	
			11.00	12.00	12.01	13.00	13.01	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
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
70.50	03951	SLEEP LAB	0	0	0	0	0	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	INDUSTRIAL MEDICINE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet D-1 | Date/Time Prepared: 5/7/2014 3:38 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	11,748	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,748	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)	11,416	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)	6,451	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,685,766	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,685,766	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,685,766	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	569.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,671,264	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)	3,671,264	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet D-1 | Date/Time Prepared: 5/7/2014 3:38 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,759,343	1,632	1,078.03	1,040	1,121,151	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	4,376,156	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	9,168,571	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)	190,021	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	97,404	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	287,425	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	8,881,146	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)	332	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	569.10	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	188,941	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet D-1 | Date/Time Prepared: 5/7/2014 3:38 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	304,776	6,685,766	0.045586	188,941	8,613	90.00
91.00	Nursing School cost	0	6,685,766	0.000000	188,941	0	91.00
92.00	Allied health cost	0	6,685,766	0.000000	188,941	0	92.00
93.00	All other Medical Education	0	6,685,766	0.000000	188,941	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet D-1 | Date/Time Prepared: 5/7/2014 3:38 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	11,748	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,748	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)	11,416	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)	3,194	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
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,685,766	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,685,766	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,685,766	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	569.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,817,705	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,817,705	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet D-1 | Date/Time Prepared: 5/7/2014 3:38 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,759,343	1,632	1,078.03	416	448,460	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,266,165	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)	91,925	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	91,925	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,174,240	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)	332	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	569.10	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	188,941	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet D-1 | Date/Time Prepared: 5/7/2014 3:38 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	304,776	6,685,766	0.045586	188,941	8,613	90.00
91.00	Nursing School cost	0	6,685,766	0.000000	188,941	0	91.00
92.00	Allied health cost	0	6,685,766	0.000000	188,941	0	92.00
93.00	All other Medical Education	0	6,685,766	0.000000	188,941	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet D-3 | Date/Time Prepared: 5/7/2014 3:38 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		8,372,100		30.00
31.00	03100	INTENSIVE CARE UNIT		1,560,000		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.474622	1,173,867	557,143	50.00
51.00	05100	RECOVERY ROOM	0.149359	281,423	42,033	51.00
53.00	05300	ANESTHESIOLOGY	0.026689	1,057,014	28,211	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.288026	1,751,583	504,501	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
60.00	06000	LABORATORY	0.208467	3,876,712	808,167	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.228744	1,603,291	366,743	65.00
66.00	06600	PHYSICAL THERAPY	0.682757	264,022	180,263	66.00
69.00	06900	ELECTROCARDIOLOGY	0.071150	873,229	62,130	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.073659	70,356	5,182	70.00
70.50	03951	SLEEP LAB	0.159502	0	0	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	0.632422	1,136,455	718,719	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.430903	338,520	145,869	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.183872	4,557,399	837,978	73.00
74.00	07400	RENAL DIALYSIS	0.166904	68,251	11,391	74.00
76.00	03950	INDUSTRIAL MEDICINE	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.835916	10,812	9,038	90.00
91.00	09100	EMERGENCY	0.285528	345,982	98,788	91.00
92.00	09200	OBSERVATION BEDS	0.375636	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		17,408,916	4,376,156	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)		17,408,916		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet D-3 | Date/Time Prepared: 5/7/2014 3:38 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.474622	0	0	50.00
51.00	05100	RECOVERY ROOM	0.149359	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.026689	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.288026	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
60.00	06000	LABORATORY	0.208467	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.228744	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.682757	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.071150	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.073659	0	0	70.00
70.50	03951	SLEEP LAB	0.159502	0	0	70.50
71.00	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	0.632422	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.430903	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.183872	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.166904	0	0	74.00
76.00	03950	INDUSTRIAL MEDICINE	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.835916	0	0	90.00
91.00	09100	EMERGENCY	0.285528	0	0	91.00
92.00	09200	OBSERVATION BEDS	0.375636	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet E Part A | Date/Time Prepared: 5/7/2014 3:38 pm

Title XVIII | Hospital | PPS

			before 1/1	on/after 1/1	
		0	1.00	1.01	
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		8,421,261		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013 (see instructions)		0		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		0		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)		27,127		2.00
2.01	Outlier reconciliation amount		0		2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0		2.02
3.00	Managed Care Simulated Payments		0		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		112.26		4.00
	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		4.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		4.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		6.00		11.00
12.00	Current year allowable FTE (see instructions)		6.00		12.00
13.00	Total allowable FTE count for the prior year.		4.89		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.		5.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		5.30		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjusment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		5.30		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.047212		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.041385		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.041385		21.00
22.00	IME payment adjustment (see instructions)		188,257		22.00
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)		0		28.00
29.00	Total IME payment (sum of lines 22 and 28)		188,257		29.00
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		23.48		30.00
31.00	Percentage of Medicaid patient days (see instructions)		29.30		31.00
32.00	Sum of lines 30 and 31		52.78		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet E Part A Date/Time Prepared: 5/7/2014 3:38 pm

Title XVIII | Hospital | PPS

			before 1/1	on/after 1/1	
		0	1.00	1.01	
33.00	Allowable disproportionate share percentage (see instructions)		32.76		33.00
34.00	Disproportionate share adjustment (see instructions)		2,758,805		34.00
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)				35.00
35.01	Factor 3 (see instructions)				35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)				35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)				35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)				36.00
	Additional payment for high percentage of ESRD beneficiary discharges				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 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 an 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)		11,395,450		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)		11,395,450		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		779,140		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).		186,570		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0		55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0		56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).		0		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		12,361,160		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		12,361,160		61.00
62.00	Deductibles billed to program beneficiaries		795,813		62.00
63.00	Coinsurance billed to program beneficiaries		221,020		63.00
64.00	Allowable bad debts (see instructions)		894,698		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		626,289		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		688,289		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		11,970,616		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0		68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96).(For SCH see instructions)		0		69.00
70.00			0		70.00
70.92	Bundled Model 1 discount amount		0		70.92
70.93	HVBP incentive payment (see instructions)		-38,914		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		-35,384		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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet E Part A Date/Time Prepared: 5/7/2014 3:38 pm

Title XVIII | Hospital | PPS

			before 1/1	on/after 1/1	
		0	1.00	1.01	
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)		11,896,318		71.00
71.01	Sequestration adjustment (see instructions)		68,999		71.01
72.00	Interim payments		11,826,792		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		527		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		33,315		75.00
	TO BE COMPLETED BY CONTRACTOR				
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the Time Value of Money		0.00		94.00
95.00	Time Value of Money for operating expenses(see instructions)		0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)		0		96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet E Part B Date/Time Prepared: 5/7/2014 3:38 pm

Title XVIII | Hospital | PPS

		before 1/1	on/after 1/1	
		1.00	1.01	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)	3		1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	3,391,853	0	2.00
3.00	PPS payments	2,201,119	0	3.00
4.00	Outlier payment (see instructions)	59,385	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	0.000	5.00
6.00	Line 2 times line 5	0	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	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)	3		11.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable charges			
12.00	Ancillary service charges	11		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)	11		14.00
	Customary charges			
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0		15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis 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)	11		18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	8		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)	3		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)	2,260,504		24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25.00	Deductibles and coinsurance (for CAH, see instructions)	31,989		25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	489,660		26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	1,738,858		27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	69,021		28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0		29.00
30.00	Subtotal (sum of lines 27 through 29)	1,807,879		30.00
31.00	Primary payer payments	0		31.00
32.00	Subtotal (line 30 minus line 31)	1,807,879		32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0		33.00
34.00	Allowable bad debts (see instructions)	527,668		34.00
35.00	Adjusted reimbursable bad debts (see instructions)	369,368		35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	350,753		36.00
37.00	Subtotal (see instructions)	2,177,247		37.00
38.00	MSP-LCC reconciliation amount from PS&R	0		38.00
39.00	FDO LOSS	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)	2,177,247		40.00
40.01	Sequestration adjustment (see instructions)	12,628		40.01
41.00	Interim payments	1,733,892		41.00
42.00	Tentative settlement (for contractors use only)	0		42.00
43.00	Balance due provider/program (see instructions)	430,727		43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0		44.00
	TO BE COMPLETED BY CONTRACTOR			
90.00	Original outlier amount (see instructions)	0		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0		91.00
92.00	The rate used to calculate the Time Value of Money	0.00		92.00
93.00	Time Value of Money (see instructions)	0		93.00
94.00	Total (sum of lines 91 and 93)	0		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet E-1 Part I | Date/Time Prepared: 5/7/2014 3:38 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		11,754,452		1,733,892	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	01/03/2013	72,340		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		72,340		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		11,826,792		1,733,892	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		527		430,727	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		11,827,319		2,164,619	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	Provider CCN: 140151	Period: From 07/01/2012 To 07/20/2013	Worksheet E-3 Part VII Date/Time Prepared: 5/7/2014 3:38 pm
	Title XIX	Hospital	PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
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
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	8,719,995		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)	8,719,995	0	12.00
	CUSTOMARY CHARGES			
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)	8,719,995	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	8,719,995	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
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
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
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
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	0	32.00
33.00	Coinsurance	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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet E-4 | Date/Time Prepared: 5/7/2014 3:38 pm

Title XVIII | Hospital | PPS

				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	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			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	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.	0.00	0.00	0.00	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.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		6.00		10.00
11.00	Total weighted FTE count	0.00	6.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	3.90		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	4.50		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	4.80		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	0.00	4.80		17.00
18.00	Per resident amount	0.00	92,653.10		18.00
19.00	Approved amount for resident costs	0	444,735	444,735	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)			444,735	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions)	7,491	9		26.00
27.00	Total Inpatient Days (see instructions)	13,048	13,048		27.00
28.00	Ratio of inpatient days to total inpatient days	0.574111	0.000690		28.00
29.00	Program direct GME amount	255,327	307		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		43		30.00
31.00	Net Program direct GME amount			255,591	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 140151	Period: From 07/01/2012 To 07/20/2013	Worksheet E-4 Date/Time Prepared: 5/7/2014 3:38 pm
	Title XVIII	Hospital	PPS

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)		
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)	86,451	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
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	9,168,571	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)	0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	9,168,571	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	3,391,856	42.00
43.00	Primary payer payments (see instructions)	0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	3,391,856	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	12,560,427	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.729957	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.270043	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	255,591	48.00
49.00	Part A Medicare GME payment (line 46 x 48)(Title XVIII only)(see instructions)	186,570	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	69,021	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet G | Date/Time Prepared: 5/7/2014 3:38 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	499,856	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,974,853	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	762,601	0	0	0	7.00
8.00	Prepaid expenses	148,717	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	-2,128,037	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	2,257,990	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	4,507,827	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	4,507,827	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	9,204,525	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	9,204,525	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	15,970,342	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,062,046	0	0	0	37.00
38.00	Salaries, wages, and fees payable	599,717	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	300,000	0	0	0	43.00
44.00	Other current liabilities	793,599	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,755,362	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	400,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	400,000	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	4,155,362	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	11,814,980				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	11,814,980	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	15,970,342	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet G-1 | Date/Time Prepared: 5/7/2014 3:38 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		9,140,112		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,674,868				2.00
3.00	Total (sum of line 1 and line 2)		11,814,980		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		11,814,980		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		11,814,980		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 140151 | Period: From 07/01/2012 To 07/20/2013 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/7/2014 3:38 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	13,962,725		13,962,725	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)	13,962,725		13,962,725	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	2,776,722		2,776,722	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	2,776,722		2,776,722	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	16,739,447		16,739,447	17.00
18.00	Ancillary services	27,604,629	26,373,894	53,978,523	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER PATIENT REVENUES	0	1,131,763	1,131,763	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	44,344,076	27,505,657	71,849,733	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		28,137,205		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	ADD EXP FROM 7/1/13 TO 7/20/13..A-8	490,431			31.00
32.00	BAD DEBT/ALLOWANCES 7/1-7/20/13	216,122			32.00
33.00	MEDICARE PENALTY	1,068,816			33.00
34.00	ROUNDING	-3			34.00
35.00	VARIANCE BETWEEN COST REPORT AND F/S	23,958			35.00
36.00	Total additions (sum of lines 30-35)		1,799,324		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)		29,936,529		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 140151	Period: From 07/01/2012 To 07/20/2013	Worksheet G-3 Date/Time Prepared: 5/7/2014 3:38 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	71,849,733	1.00
2.00	Less contractual allowances and discounts on patients' accounts	39,732,915	2.00
3.00	Net patient revenues (line 1 minus line 2)	32,116,818	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	29,936,529	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,180,289	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	77	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	36,101	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	4,377	17.00
18.00	Revenue from sale of medical records and abstracts	12,265	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	2,497	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	4,587	24.00
24.01	GRANT INCOME	17,552	24.01
24.02	OTHER OP REV 7/1 TO 7/20	567	24.02
24.03	ER PROF FEEES	58,848	24.03
24.04	ANEST PROF FEES	354,063	24.04
24.05	EEG PROF FEES	3,645	24.05
25.00	Total other income (sum of lines 6-24)	494,579	25.00
26.00	Total (line 5 plus line 25)	2,674,868	26.00
27.00	INCOME TAX EXPENSE	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,674,868	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140151	Period: From 07/01/2012 To 07/20/2013	Worksheet L Parts I-III Date/Time Prepared: 5/7/2014 3:38 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	672,818	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	84	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	33.89	3.00
4.00	Number of interns & residents (see instructions)	5.30	4.00
5.00	Indirect medical education percentage (see instructions)	4.51	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)	30,344	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	23.48	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	29.30	8.00
9.00	Sum of lines 7 and 8	52.78	9.00
10.00	Allowable disproportionate share percentage (see instructions)	11.28	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)	75,894	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	779,140	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00