

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: 140275	Period: From 07/01/2012 To 06/30/2013	Worksheet S Parts I-III Date/Time Prepared: 11/22/2013 8:42 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/22/2013 Time: 8:42 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GMC - ILLINI (140275) for the cost reporting period beginning 07/01/2012 and ending 06/30/2013 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)

CFO

Title

11/26/2013

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-418,894	30,520	1,250,803	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
8.00 NURSING FACILITY	0	0	0	0	0	8.00
200.00 Total	0	-418,894	30,520	1,250,803	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: 140275	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 11/22/2013 8:42 am
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1.00	2.00	3.00	4.00	1.00	2.00
Hospital and Hospital Health Care Complex Address:					
Street: 801 HOSPITAL ROAD		PO Box:			
City: SILVIS		State: IL		Zip Code: 61282-	
				County: ROCK ISLAND	

	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	GMC - ILLINI	140275	19340	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	ILLINI RESTORATIVE CARE CENTER	145703	19340		09/03/1991	N	P	N	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	06/30/2013	20.00
21.00	Type of Control (see instructions)	2		21.00

Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00
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.					3	N			23.00

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days		
1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	2,544	447	0	68	64	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

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		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	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.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	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 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN and general surgery) added as a result of section 5503. (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 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 4.00
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.				0.00	0.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140275		Period: From 07/01/2012 To 06/30/2013		Worksheet S-2 Part I Date/Time Prepared: 11/22/2013 8:42 am	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
					1.00	2.00	3.00
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

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		V 1.00	XIX 2.00			
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)					107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00
				1.00	2.00	3.00
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.	N				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	0	0	266,420		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 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		H55790		140.00

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1.00		2.00		3.00				
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.								
141.00	Name: GENESIS HEALTH SYSTEM	Contractor's Name: WPS		Contractor's Number: 05101		141.00		
142.00	Street: 1227 E. RUSHOLME STREET	PO Box:		Zip Code: 52803		142.00		
143.00	City: DAVENPORT	State: IA		143.00				
1.00								
144.00	Are provider based physicians' costs included in Worksheet A?						Y 144.00	
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.						N 145.00	
1.00 2.00								
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						N 146.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N 147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N 148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N 149.00	
		Part A	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								
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N 165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00 166.00	
1.00								
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						Y 167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						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)						0.75 169.00	
		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)						07/01/2012 06/30/2013 170.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140275	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part II Date/Time Prepared: 11/22/2013 8:42 am	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N		14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N		15.00
		Part A		Part B	
		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	10/04/2013	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: 140275	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part II Date/Time Prepared: 11/22/2013 8:42 am
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	Description	Part A		Part B		
		Y/N	Date	Y/N		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	1.00	2.00	3.00	21.00
		N			N	
				1.00		
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)						
Capital Related Cost						
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
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?				Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				Y	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				N	40.00
				1.00	2.00	
Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MARTIN		ORWITZ		41.00
42.00	Enter the employer/company name of the cost report preparer.	GENESIS HEALTH SYSTEM				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-421-4175		ORWITZM@GENESISHEALTH.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet S-2
Part II
Date/Time Prepared:
11/22/2013 8:42 am

		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)	10/04/2013		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.	DIRECTOR, REIMBURSEMENT		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: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet S-3
Part I
Date/Time Prepared:
11/22/2013 8:42 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	142	51,830	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)		142	51,830	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	7	2,555	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		149	54,385	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	44.00	83	30,295		0	19.00
20.00 NURSING FACILITY	45.00	37	13,505		0	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)		269				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: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet S-3
Part I
Date/Time Prepared:
11/22/2013 8:42 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,021	1,619	11,798			1.00
2.00 HMO and other (see instructions)	1,239	692				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	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	6,021	1,619	11,798			7.00
8.00 INTENSIVE CARE UNIT	641	84	1,125			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		728	1,192			13.00
14.00 Total (see instructions)	6,662	2,431	14,115	0.00	476.72	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	6,955	6,215	22,773	0.00	93.22	19.00
20.00 NURSING FACILITY		0	11,643	0.00	5.99	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	575.93	27.00
28.00 Observation Bed Days		26	1,448			28.00
29.00 Ambulance Trips	3,273					29.00
30.00 Employee discount days (see instruction)			271			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet S-3
Part I
Date/Time Prepared:
11/22/2013 8:42 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,723	973	4,589	1.00
2.00 HMO and other (see instructions)			347			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	1,723	973	4,589	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	0.00					19.00
20.00 NURSING FACILITY	0.00					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: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet S-3
Part II
Date/Time Prepared:
11/22/2013 8:42 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	27,873,261	0	27,873,261	996,223.00	27.98
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	2,717,249	252,750	2,969,999	150,704.00	19.71
10.00	Excluded area salaries (see instructions)		2,606,135	896,577	3,502,712	208,884.00	16.77
OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		426,108	0	426,108	5,743.00	74.20
12.00	Contract management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		104,711	0	104,711	2,080.00	50.34
14.00	Home office salaries & wage-related costs		8,656,176	0	8,656,176	175,769.00	49.25
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		5,333,976	0	5,333,976		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		1,712,690	0	1,712,690		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FOHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	19,854	0	19,854	1,470.00	13.51
27.00	Administrative & General	5.00	1,144,933	0	1,144,933	27,281.00	41.97
28.00	Administrative & General under contract (see inst.)		159,451	0	159,451	1,253.00	127.26
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	963,890	0	963,890	48,000.00	20.08
31.00	Laundry & Linen Service	8.00	51,560	-18,886	32,674	2,686.00	12.16
32.00	Housekeeping	9.00	503,334	-29,126	474,208	34,123.00	13.90
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	1,226,732	-1,101,315	125,417	16,134.00	7.77
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	689,047	0	689,047	21,867.00	31.51
39.00	Central Services and Supply	14.00	84,705	0	84,705	6,019.00	14.07
40.00	Pharmacy	15.00	1,430,664	0	1,430,664	34,148.00	41.90
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet S-3
Part II
Date/Time Prepared:
11/22/2013 8:42 am

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

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet S-3
Part III
Date/Time Prepared:
11/22/2013 8:42 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	28,032,712	0	28,032,712	997,476.00	28.10	1.00
2.00	Excluded area salaries (see instructions)	5,323,384	1,149,327	6,472,711	359,588.00	18.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	22,709,328	-1,149,327	21,560,001	637,888.00	33.80	3.00
4.00	Subtotal other wages & related costs (see inst.)	9,186,995	0	9,186,995	183,592.00	50.04	4.00
5.00	Subtotal wage-related costs (see inst.)	5,333,976	0	5,333,976	0.00	24.74	5.00
6.00	Total (sum of lines 3 thru 5)	37,230,299	-1,149,327	36,080,972	821,480.00	43.92	6.00
7.00	Total overhead cost (see instructions)	6,274,170	-1,149,327	5,124,843	192,981.00	26.56	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140275	Period: From 07/01/2012 To 06/30/2013	Worksheet S-3 Part IV Date/Time Prepared: 11/22/2013 8:42 am
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		736,521	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)		3,573,885	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		49,475	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)		119,753	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		698,303	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		1,699,274	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		62,615	19.00
20.00	State or Federal Unemployment Taxes		0	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		84	22.00
23.00	Tuition Reimbursement		106,755	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		7,046,665	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 140275	Period: From 07/01/2012 To 06/30/2013	Worksheet S-3 Part V Date/Time Prepared: 11/22/2013 8:42 am
Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	426,108	7,046,665	1.00
2.00	Hospital	426,108	7,046,665	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	0	0	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet S-7

Date/Time Prepared:
11/22/2013 8:42 am

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N		2.00

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
				1.00	2.00
3.00	RUX	13	0	13	3.00
4.00	RUL	14	0	14	4.00
5.00	RVX	14	0	14	5.00
6.00	RVL	137	0	137	6.00
7.00	RHX	0	0	0	7.00
8.00	RHL	22	0	22	8.00
9.00	RMX	23	0	23	9.00
10.00	RML	14	0	14	10.00
11.00	RLX	0	0	0	11.00
12.00	RUC	484	0	484	12.00
13.00	RUB	839	0	839	13.00
14.00	RUA	545	0	545	14.00
15.00	RVC	662	0	662	15.00
16.00	RVB	1,385	0	1,385	16.00
17.00	RVA	1,428	0	1,428	17.00
18.00	RHC	132	0	132	18.00
19.00	RHB	456	0	456	19.00
20.00	RHA	301	0	301	20.00
21.00	RMC	48	0	48	21.00
22.00	RMB	110	0	110	22.00
23.00	RMA	121	0	121	23.00
24.00	RLB	2	0	2	24.00
25.00	RLA	0	0	0	25.00
26.00	ES3	0	0	0	26.00
27.00	ES2	0	0	0	27.00
28.00	ES1	0	0	0	28.00
29.00	HE2	0	0	0	29.00
30.00	HE1	1	0	1	30.00
31.00	HD2	0	0	0	31.00
32.00	HD1	0	0	0	32.00
33.00	HC2	32	0	32	33.00
34.00	HC1	1	0	1	34.00
35.00	HB2	0	0	0	35.00
36.00	HB1	21	0	21	36.00
37.00	LE2	8	0	8	37.00
38.00	LE1	0	0	0	38.00
39.00	LD2	9	0	9	39.00
40.00	LD1	28	0	28	40.00
41.00	LC2	0	0	0	41.00
42.00	LC1	0	0	0	42.00
43.00	LB2	8	0	8	43.00
44.00	LB1	0	0	0	44.00
45.00	CE2	0	0	0	45.00
46.00	CE1	7	0	7	46.00
47.00	CD2	0	0	0	47.00
48.00	CD1	1	0	1	48.00
49.00	CC2	0	0	0	49.00
50.00	CC1	23	0	23	50.00
51.00	CB2	0	0	0	51.00
52.00	CB1	2	0	2	52.00
53.00	CA2	0	0	0	53.00
54.00	CA1	24	0	24	54.00
55.00	SE3	0	0	0	55.00
56.00	SE2	0	0	0	56.00
57.00	SE1	0	0	0	57.00
58.00	SSC	0	0	0	58.00
59.00	SSB	0	0	0	59.00
60.00	SSA	0	0	0	60.00
61.00	IB2	0	0	0	61.00
62.00	IB1	0	0	0	62.00
63.00	IA2	0	0	0	63.00
64.00	IA1	0	0	0	64.00
65.00	BB2	0	0	0	65.00
66.00	BB1	1	0	1	66.00
67.00	BA2	0	0	0	67.00
68.00	BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet S-7

Date/Time Prepared:
11/22/2013 8:42 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	6	0	6	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	12	0	12	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	20	0	20	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	1	0	1	199.00
200.00	TOTAL		6,955	0	6,955	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	

201.00	SNF SERVICES	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	19340	19340	201.00
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		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

202.00	Staffing	2,536,805	65.45	Y	202.00
203.00	Recruitment	0	0.00	N	203.00
204.00	Retention of employees	519	0.01	Y	204.00
205.00	Training	3,701	0.10	Y	205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	3,875,648			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140275	Period: From 07/01/2012 To 06/30/2013	Worksheet S-10 Date/Time Prepared: 11/22/2013 8:42 am
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			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)		0.346437	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		11,379,834	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		29,439,504	6.00	
7.00	Medicaid cost (line 1 times line 6)		10,198,933	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	
			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	6,710,962	0	6,710,962	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	2,324,926	0	2,324,926	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)	2,324,926	0	2,324,926	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)		6,897,059	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		317,455	27.00	
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)		6,579,604	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		2,279,418	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		4,604,344	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		4,604,344	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet A
Date/Time Prepared:
11/22/2013 8:42 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)			
		1.00	2.00	3.00	4.00	5.00			
GENERAL SERVICE COST CENTERS									
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,742,164		1,742,164	-138,125	1,604,039	1.00
1.01	00101	NEW CAP RELATED IRC		550,784		550,784	0	550,784	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2,254,516		2,254,516	0	2,254,516	2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC		0		0	0	0	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS		0		0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	19,854	4,191,125	4,210,979	0	0	4,210,979	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,144,933	22,033,252	23,178,185	0	0	23,178,185	5.00
7.00	00700	OPERATION OF PLANT	963,890	2,031,250	2,995,140	0	0	2,995,140	7.00
7.01	00701	OPERATION OF PLANT IRC	0	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	51,560	58,654	110,214	-40,371	0	69,843	8.00
9.00	00900	HOUSEKEEPING	503,334	164,888	668,222	-38,668	0	629,554	9.00
10.00	01000	DIETARY	1,226,732	2,088,408	3,315,140	-2,818,048	0	497,092	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	689,047	92,378	781,425	0	0	781,425	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	84,705	183,704	268,409	0	0	268,409	14.00
15.00	01500	PHARMACY	1,430,664	266,227	1,696,891	0	0	1,696,891	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	5,247,138	1,805,869	7,053,007	-349,884	0	6,703,123	30.00
31.00	03100	INTENSIVE CARE UNIT	798,264	162,780	961,044	0	0	961,044	31.00
43.00	04300	NURSERY	0	0	0	349,884	0	349,884	43.00
44.00	04400	SKILLED NURSING FACILITY	2,717,249	922,266	3,639,515	602,277	0	4,241,792	44.00
45.00	04500	NURSING FACILITY	307,485	36,335	343,820	192,851	0	536,671	45.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	1,401,201	1,234,266	2,635,467	0	0	2,635,467	50.00
53.00	05300	ANESTHESIOLOGY	204	219,866	220,070	0	0	220,070	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	926,877	137,493	1,064,370	0	0	1,064,370	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	86,675	160,062	246,737	0	0	246,737	55.00
57.00	05700	CT SCAN	163,673	46,307	209,980	0	0	209,980	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	75,299	105,717	181,016	0	0	181,016	58.00
59.00	05900	CARDIAC CATHETERIZATION	359,809	430,466	790,275	0	0	790,275	59.00
60.00	06000	LABORATORY	2,047,713	3,218,651	5,266,364	0	0	5,266,364	60.00
65.00	06500	RESPIRATORY THERAPY	1,090,804	313,411	1,404,215	0	0	1,404,215	65.00
66.00	06600	PHYSICAL THERAPY	1,920,776	394,462	2,315,238	0	0	2,315,238	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,346,076	5,346,076	-3,608,342	0	1,737,734	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	3,608,342	0	3,608,342	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,759,838	2,759,838	0	0	2,759,838	73.00
76.00	03020	CARDIAC REHAB	389,393	170,678	560,071	0	0	560,071	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	93,262	9,055	102,317	0	0	102,317	90.00
90.01	09001	WOUND CENTER	35,181	103,247	138,428	0	0	138,428	90.01
91.00	09100	EMERGENCY	1,798,889	3,667,022	5,465,911	0	0	5,465,911	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)							92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	1,973,171	968,114	2,941,285	25,823	0	2,967,108	95.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE		0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,547,782	57,869,331	85,417,113	-2,214,261	0	83,202,852	118.00
NONREIMBURSABLE COST CENTERS									
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	38,601	38,601	7,088	0	45,689	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,023	182,647	187,670	2,886	0	190,556	192.00
192.01	19201	NONREIMBURSABLE	8,489	173,037	181,526	141,249	0	322,775	192.01
194.00	07950	CROSSTOWN SQUARE	151,677	252,795	404,472	321,444	0	725,916	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	1,046,034	0	1,046,034	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	695,560	0	695,560	194.03
194.04	07951	OUTREACH	160,290	25,147	185,437	0	0	185,437	194.04
200.00		TOTAL (SUM OF LINES 118-199)	27,873,261	58,541,558	86,414,819	0	0	86,414,819	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet A
Date/Time Prepared:
11/22/2013 8:42 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,165,402	2,769,441	1.00
1.01	00101	NEW CAP RELATED IRC	-204,613	346,171	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	2,254,516	2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC	0	0	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-966,767	3,244,212	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-9,713,037	13,465,148	5.00
7.00	00700	OPERATION OF PLANT	-79,904	2,915,236	7.00
7.01	00701	OPERATION OF PLANT IRC	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	69,843	8.00
9.00	00900	HOUSEKEEPING	-87,719	541,835	9.00
10.00	01000	DIETARY	0	497,092	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	781,425	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	575,344	843,753	14.00
15.00	01500	PHARMACY	-253	1,696,638	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	971,462	971,462	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-780,256	5,922,867	30.00
31.00	03100	INTENSIVE CARE UNIT	-11,538	949,506	31.00
43.00	04300	NURSERY	0	349,884	43.00
44.00	04400	SKILLED NURSING FACILITY	-165,109	4,076,683	44.00
45.00	04500	NURSING FACILITY	0	536,671	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-213,412	2,422,055	50.00
53.00	05300	ANESTHESIOLOGY	-176,377	43,693	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,064,370	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	246,737	55.00
57.00	05700	CT SCAN	0	209,980	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	181,016	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	790,275	59.00
60.00	06000	LABORATORY	-55,644	5,210,720	60.00
65.00	06500	RESPIRATORY THERAPY	-55,114	1,349,101	65.00
66.00	06600	PHYSICAL THERAPY	-108,811	2,206,427	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,737,734	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,608,342	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,759,838	73.00
76.00	03020	CARDIAC REHAB	-5,744	554,327	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-194	102,123	90.00
90.01	09001	WOUND CENTER	-32,531	105,897	90.01
91.00	09100	EMERGENCY	-3,245,344	2,220,567	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-1,085,392	1,881,716	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-14,275,551	68,927,301	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	45,689	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	190,556	192.00
192.01	19201	NONREIMBURSABLE	0	322,775	192.01
194.00	07950	CROSSTOWN SQUARE	-95,996	629,920	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	1,046,034	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	695,560	194.03
194.04	07951	OUTREACH	0	185,437	194.04
200.00		TOTAL (SUM OF LINES 118-199)	-14,371,547	72,043,272	200.00

RECLASSIFICATIONS

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-6

Date/Time Prepared:
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		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - POB DEPRECIATION					
1.00	NONREIMBURSABLE	192.01	0	138,125	1.00
	TOTALS		0	138,125	
B - NURSING HOME OVERHEAD COSTS					
1.00	SKILLED NURSING FACILITY	44.00	40,557	25,735	1.00
	TOTALS		40,557	25,735	
C - NURSERY COSTS					
1.00	NURSERY	43.00	290,605	59,279	1.00
	TOTALS		290,605	59,279	
D - CHARGEABLE SUPPLIES					
1.00	IMPL. DEV. CHARGED TO	72.00	0	3,608,342	1.00
	PATIENT				
	TOTALS		0	3,608,342	
E - DIETARY COST AND EMPLOYEE MEALS					
1.00	SKILLED NURSING FACILITY	44.00	195,635	304,956	1.00
2.00	NURSING FACILITY	45.00	100,021	155,913	2.00
3.00	CROSTOWN SQUARE	194.00	125,031	194,898	3.00
4.00	NONALLOWABLE PHYSICIAN	194.02	408,798	637,236	4.00
5.00	NONALLOWABLE GUEST MEALS	194.03	271,830	423,730	5.00
	TOTALS		1,101,315	1,716,733	
F - RECLASS HOUSEKEEPING COST					
1.00	AMBULANCE SERVICES	95.00	19,451	6,372	1.00
2.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	5,339	1,749	2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	1,983	650	3.00
4.00	NONREIMBURSABLE	192.01	2,353	771	4.00
	TOTALS		29,126	9,542	
G - RECLASS LAUNDRY COST					
1.00	SKILLED NURSING FACILITY	44.00	16,558	18,836	1.00
2.00	NURSING FACILITY	45.00	1,501	1,708	2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	118	135	3.00
4.00	CROSTOWN SQUARE	194.00	709	806	4.00
	TOTALS		18,886	21,485	
500.00	Grand Total: Increases		1,480,489	5,579,241	500.00

RECLASSIFICATIONS

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-6

Date/Time Prepared:
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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - POB DEPRECIATION							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	138,125		9	1.00
	TOTALS		0	138,125			
B - NURSING HOME OVERHEAD COSTS							
1.00	NURSING FACILITY	45.00	40,557	25,735		9	1.00
	TOTALS		40,557	25,735			
C - NURSERY COSTS							
1.00	ADULTS & PEDIATRICS	30.00	290,605	59,279		9	1.00
	TOTALS		290,605	59,279			
D - CHARGEABLE SUPPLIES							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,608,342		11	1.00
	TOTALS		0	3,608,342			
E - DIETARY COST AND EMPLOYEE MEALS							
1.00	DIETARY	10.00	1,101,315	1,716,733		0	1.00
2.00		0.00	0	0		0	2.00
3.00		0.00	0	0		0	3.00
4.00		0.00	0	0		0	4.00
5.00		0.00	0	0		0	5.00
	TOTALS		1,101,315	1,716,733			
F - RECLASS HOUSEKEEPING COST							
1.00	HOUSEKEEPING	9.00	29,126	9,542		0	1.00
2.00		0.00	0	0		0	2.00
3.00		0.00	0	0		0	3.00
4.00		0.00	0	0		0	4.00
	TOTALS		29,126	9,542			
G - RECLASS LAUNDRY COST							
1.00	LAUNDRY & LINEN SERVICE	8.00	18,886	21,485		0	1.00
2.00		0.00	0	0		0	2.00
3.00		0.00	0	0		0	3.00
4.00		0.00	0	0		0	4.00
	TOTALS		18,886	21,485			
500.00	Grand Total: Decreases		1,480,489	5,579,241			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-7
Part I
Date/Time Prepared:
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		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,355,591	18,531	0	18,531	0	1.00
2.00	Land Improvements	1,728,047	108,175	0	108,175	0	2.00
3.00	Buildings and Fixtures	55,054,368	1,533,844	0	1,533,844	0	3.00
4.00	Building Improvements	16,771	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	41,493,730	1,854,956	0	1,854,956	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	100,648,507	3,515,506	0	3,515,506	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	100,648,507	3,515,506	0	3,515,506	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,374,122	0				1.00
2.00	Land Improvements	1,836,222	0				2.00
3.00	Buildings and Fixtures	56,588,212	0				3.00
4.00	Building Improvements	16,771	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	43,348,686	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	104,164,013	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	104,164,013	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-7
Part II
Date/Time Prepared:
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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	NEW CAP REL COSTS-BLDG & FIXT	1,742,164	0	0	0	0	1.00
1.01	NEW CAP RELATED IRC	550,784	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,254,516	0	0	0	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	4,547,464	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	NEW CAP REL COSTS-BLDG & FIXT	0	1,742,164				1.00
1.01	NEW CAP RELATED IRC	0	550,784				1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2,254,516				2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0				2.01
3.00	Total (sum of lines 1-2)	0	4,547,464				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-7
Part III
Date/Time Prepared:
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	46,429,092	0	46,429,092	0.445278	0	1.00
1.01	NEW CAP RELATED IRC	16,507,125	0	16,507,125	0.158312	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	41,333,604	0	41,333,604	0.396410	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	104,269,821	0	104,269,821	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	3,126,501	-182,948	1.00
1.01	NEW CAP RELATED IRC	0	0	0	550,784	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	2,254,516	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	5,931,801	-182,948	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	-174,112	0	0	0	2,769,441	1.00
1.01	NEW CAP RELATED IRC	-204,613	0	0	0	346,171	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,254,516	2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	-378,725	0	0	0	5,370,128	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-8

Date/Time Prepared:
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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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
1.01 Investment income - NEW CAP RELATED IRC (chapter 2)			ONEW CAP RELATED IRC	1.01		0	1.01
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
2.01 Investment income - CAP REL COSTS-MVBLE EQUIP IRC (chapter 2)			OCAP REL COSTS-MVBLE EQUIP IRC	2.01		0	2.01
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	-4,496,829				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	-1,908,047				0	12.00
13.00 Laundry and linen service		0		0.00		0	13.00
14.00 Cafeteria-employees and guests		0		0.00		0	14.00
15.00 Rental of quarters to employee and others		0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00		0	16.00
17.00 Sale of drugs to other than patients		0		0.00		0	17.00
18.00 Sale of medical records and abstracts		0		0.00		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00		0	19.00
20.00 Vending machines		0		0.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		ORESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			ONEW CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
26.01 Depreciation - NEW CAP RELATED IRC			ONEW CAP RELATED IRC	1.01		0	26.01
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			ONEW CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
27.01 Depreciation - CAP REL COSTS-MVBLE EQUIP IRC			OCAP REL COSTS-MVBLE EQUIP IRC	2.01		0	27.01
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant			0	0.00		0	29.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140275

Period:
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Worksheet A-8

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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
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 AMBULANCE - CPE REVENUE	B	-49,681	AMBULANCE SERVICES		95.00	0 33.00
34.00 AMBULANCE - MISCELLANEOUS REVENUE	B	-611,159	AMBULANCE SERVICES		95.00	0 34.00
35.00 AMBULANCE OUTREACH - MISCELLANEOUS R	B	-423,442	AMBULANCE SERVICES		95.00	0 35.00
35.03 PEDIATRICS - MISCELLANEOUS REVENUE	B	-125	ADULTS & PEDIATRICS		30.00	0 35.03
35.04 OP CARE CENTER - MISCELLANEOUS REVEN	B	-14,929	OPERATING ROOM		50.00	0 35.04
35.05 PHYSICAL THERAPY - MISCELLANEOUS REV	B	-610	PHYSICAL THERAPY		66.00	0 35.05
35.07 P. T. CLINIC - KING PLAZA MOLIN - INT	B	-83,799	PHYSICAL THERAPY		66.00	0 35.07
35.08 P. T. CLINIC - KING PLAZA MOLIN - MIS	B	-15,730	PHYSICAL THERAPY		66.00	0 35.08
35.09 SPEECH THERAPY - MISCELLANEOUS REVEN	B	-1,674	PHYSICAL THERAPY		66.00	0 35.09
35.11 TRAUMA - MISCELLANEOUS REVENUE	B	-53,114	EMERGENCY		91.00	0 35.11
35.13 CARDIAC REHAB - MISCELLANEOUS REVENU	B	-5,744	CARDIAC REHAB		76.00	0 35.13
35.14 DIABETES CARE CENTER - MISCELLANEOUS	B	-194	CLINIC		90.00	0 35.14
35.15		0			0.00	9 35.15
36.00 CANCER CENTER - MISCELLANEOUS REVENU	B	-3,646	ADMINISTRATIVE & GENERAL		5.00	9 36.00
36.02 STERILE PROCESSING - MISCELLANEOUS R	B	-55,955	CENTRAL SERVICES & SUPPLY		14.00	0 36.02
36.06 PHARMACY - MISCELLANEOUS REVENUE	B	-253	PHARMACY		15.00	0 36.06
36.07 ADMINISTRATION - RENTAL INCOME -3RD	B	-24,577	ADMINISTRATIVE & GENERAL		5.00	0 36.07
36.08 ADMINISTRATION - DISCOUNTS EARNED	B	-18,365	ADMINISTRATIVE & GENERAL		5.00	0 36.08
36.09 INFORMATION TECHNOLOGY - MISCELLANEO	B	-8,683	ADMINISTRATIVE & GENERAL		5.00	9 36.09
36.10 MEDICAL STAFF - ILLINI - MISCELLANEO	B	-29,130	ADMINISTRATIVE & GENERAL		5.00	0 36.10
36.11 ENVIRONMENTAL SERVICES - INTERCOMPAN	B	-87,719	HOUSEKEEPING		9.00	0 36.11
36.13 BIRTH ASSOCIATES - MISCELLANEOUS REV	B	-3,355	ADULTS & PEDIATRICS		30.00	0 36.13
36.14 GROUNDS - INTERCOMPANY REVENUE	B	-3,123	OPERATION OF PLANT		7.00	0 36.14
36.15 MAINTENANCE - INTERCOMPANY REVENUE	B	-34,931	OPERATION OF PLANT		7.00	0 36.15
36.16 MAINTENANCE - MISCELLANEOUS REVENUE	B	-2,402	OPERATION OF PLANT		7.00	0 36.16
36.17 BIOMED SERVICES - MISCELLANEOUS REVE	B	-39,448	OPERATION OF PLANT		7.00	0 36.17
36.18 GRANTS 2 - MISCELLANEOUS REVENUE	B	-27,324	ADMINISTRATIVE & GENERAL		5.00	0 36.18
36.20 SWITCHBOARD - MISCELLANEOUS REVENUE	B	-627	ADMINISTRATIVE & GENERAL		5.00	0 36.20
36.21 PHYSICIAN SUPPORT SVCS - RENTAL INCO	B	-182,948	NEW CAP REL COSTS-BLDG & FI XT		1.00	10 36.21
37.00 PHYSICIAN SUPPORT SVCS - RENTAL INCO	B	-1,320	ADMINISTRATIVE & GENERAL		5.00	0 37.00
37.01 ADMINISTRATION - MISCELLANEOUS REVEN	A	-680	ADMINISTRATIVE & GENERAL		5.00	0 37.01
37.06 INTEREST - INTEREST EXPENSE - 2010 B	A	-260,628	NEW CAP REL COSTS-BLDG & FI XT		1.00	11 37.06

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
37.07 INTEREST - INTEREST EXP CAP INT OFF	A	86,516	NEW CAP REL COSTS-BLDG & FIXT	1.00	11 37.07
37.09 INTEREST- IRC - INTEREST EXPENSE - R	A	-204,613	NEW CAP RELATED IRC	1.01	11 37.09
37.10 INTEREST - CS - INTEREST EXPENSE - R	A	-75,679	CROSTOWN SQUARE	194.00	0 37.10
37.11 NURSING FLOOR - IRC MEDICARE - CONTR	A	-42,726	SKILLED NURSING FACILITY	44.00	0 37.11
37.12 ENVIRONMENTAL SVCS - IRC - CONTRACT	A	-60,492	SKILLED NURSING FACILITY	44.00	0 37.12
37.14 ENVIRONMENTAL SVC - CS - CONTRACT FE	A	-1,608	CROSTOWN SQUARE	194.00	0 37.14
38.00		0		0.00	0 38.00
39.00		0		0.00	0 39.00
39.01 SECURITY - IRC - CONTRACT FEES- ILLI	A	-16,560	SKILLED NURSING FACILITY	44.00	0 39.01
39.02 SECURITY - CS - CONTRACT FEES- ILLIN	A	-7,755	CROSTOWN SQUARE	194.00	0 39.02
39.03 ADMINISTRATION - PHYSICIAN PRACTICE	A	-2,022,634	ADMINISTRATIVE & GENERAL	5.00	0 39.03
39.04		0		0.00	0 39.04
40.00 PHYSICIAN SUPPORT SVCS - RENTAL FACI	A	-203,379	ADMINISTRATIVE & GENERAL	5.00	0 40.00
41.00 PHYSICIAN SUPPORT SVCS - RENTAL EQUI	A	-808	ADMINISTRATIVE & GENERAL	5.00	0 41.00
42.00 PHYSICIAN SUPPORT SVCS - TELEPHONE -	A	85	ADMINISTRATIVE & GENERAL	5.00	0 42.00
43.00 ALCOHOL	A	-941	ADMINISTRATIVE & GENERAL	5.00	0 43.00
43.01 AMBULANCE - ADVERTISING & PROMOTIONS	A	-1,110	AMBULANCE SERVICES	95.00	0 43.01
43.02 LABORATORY - ADVERTISING & PROMOTION	A	-251	LABORATORY	60.00	0 43.02
43.03 PHYSICAL THERAPY - ADVERTISING & PRO	A	-2,706	PHYSICAL THERAPY	66.00	0 43.03
43.04 P. T. CLINIC - KING PLAZA MOLIN - ADV	A	-4,178	PHYSICAL THERAPY	66.00	0 43.04
43.05 PHYSICAL REHAB. - YMCA - ADVERTISING	A	-114	PHYSICAL THERAPY	66.00	0 43.05
43.06 WOUND CENTER - ADVERTISING & PROMOTI	A	-1,613	WOUND CENTER	90.01	0 43.06
43.07 ADMINISTRATION - ADVERTISING & PROMO	A	-663	ADMINISTRATIVE & GENERAL	5.00	0 43.07
43.08 CORPORATE COMMUNICATIONS - ADVERTISI	A	-427	ADMINISTRATIVE & GENERAL	5.00	0 43.08
43.09 CORP COMMUNICATION - CS - ADVERTISIN	A	-10,954	CROSTOWN SQUARE	194.00	0 43.09
43.10 ADMINISTRATION - PROVIDER TAX ASSESS	A	-2,242,174	ADMINISTRATIVE & GENERAL	5.00	0 43.10
43.11 NURSING ADMIN - IRC - PROVIDER TAX A	A	-45,331	SKILLED NURSING FACILITY	44.00	0 43.11
43.12 ADMINSTRATOR - IRC - PROVIDER TAX A	A	-94,474	ADMINISTRATIVE & GENERAL	5.00	0 43.12
43.13 SELF INSURANCE	A	-966,767	EMPLOYEE BENEFITS	4.00	0 43.13
43.14		0		0.00	0 43.14
43.15		0		0.00	0 43.15
45.00		0		0.00	0 45.00
45.01		0		0.00	0 45.01
45.02		0		0.00	0 45.02
45.03		0		0.00	0 45.03
45.04		0		0.00	0 45.04
45.05		0		0.00	0 45.05
45.06		0		0.00	0 45.06
45.07		0		0.00	0 45.07
45.08		0		0.00	0 45.08
45.09		0		0.00	0 45.09
45.10		0		0.00	0 45.10
45.11		0		0.00	0 45.11
45.12		0		0.00	0 45.12
45.13		0		0.00	0 45.13
45.14		0		0.00	0 45.14

Provider CCN: 140275

Period:
 From 07/01/2012
 To 06/30/2013

Worksheet A-8

Date/Time Prepared:
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
45.15		0			0.00	0	45.15
45.16		0			0.00	0	45.16
45.17		0			0.00	0	45.17
45.18		0			0.00	0	45.18
45.19		0			0.00	0	45.19
45.20		0			0.00	0	45.20
45.21		0			0.00	0	45.21
45.22		0			0.00	0	45.22
45.23		0			0.00	0	45.23
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	-14,371,547					50.00

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

Provider CCN: 140275

Period: From 07/01/2012 To 06/30/2013

Worksheet A-8-1

Date/Time Prepared: 11/22/2013 8:42 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	GHS HOME OFFICE COSTS	10,221,341	15,254,611 1.00
2.00	1.00	NEW CAP REL COSTS-BLDG & FIXT	GHS HOME OFFICE COSTS	1,522,462	0 2.00
3.00	0.00			0	0 3.00
4.00	14.00	CENTRAL SERVICES & SUPPLY	GHS HOME OFFICE COSTS	631,299	0 4.00
4.01	16.00	MEDICAL RECORDS & LIBRARY	GHS HOME OFFICE COSTS	971,462	0 4.01
4.02	0.00			0	0 4.02
4.03	0.00			0	0 4.03
4.04	0.00		GHS HOME OFFICE COSTS	0	0 4.04
5.00	0			13,346,564	15,254,611 5.00

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

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

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

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

6.00	C		0.00	GENESIS HEALTH SYSTEM	100.00	6.00
7.00			0.00		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: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-8-1

Date/Time Prepared:
11/22/2013 8:42 am

	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	-5,033,270	0		1.00
2.00	1,522,462	9		2.00
3.00	0	0		3.00
4.00	631,299	0		4.00
4.01	971,462	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
5.00	-1,908,047			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	HOME OFFICE		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: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-8-2

Date/Time Prepared:
11/22/2013 8:42 am

	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	60.00	LABORATORY	55,393	55,393	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	55,114	55,114	0	0	0	2.00
3.00	91.00	EMERGENCY	3,192,230	3,192,230	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	776,776	776,776	0	0	0	4.00
5.00	50.00	OPERATING ROOM	198,483	198,483	0	0	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	11,538	11,538	0	0	0	6.00
7.00	5.00	ADMINISTRATIVE & GENERAL	104,711	0	104,711	171,400	2,080	7.00
8.00	90.01	WOUND CENTER	30,918	30,918	0	0	0	8.00
9.00	53.00	ANESTHESIOLOGY	176,377	176,377	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,601,540	4,496,829	104,711		2,080	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	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	6.00
7.00	5.00	ADMINISTRATIVE & GENERAL	171,400	8,570	0	0	0	7.00
8.00	90.01	WOUND CENTER	0	0	0	0	0	8.00
9.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			171,400	8,570	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	60.00	LABORATORY	0	0	0	55,393	1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	55,114	2.00
3.00	91.00	EMERGENCY	0	0	0	3,192,230	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	776,776	4.00
5.00	50.00	OPERATING ROOM	0	0	0	198,483	5.00
6.00	31.00	INTENSIVE CARE UNIT	0	0	0	11,538	6.00
7.00	5.00	ADMINISTRATIVE & GENERAL	0	171,400	0	0	7.00
8.00	90.01	WOUND CENTER	0	0	0	30,918	8.00
9.00	53.00	ANESTHESIOLOGY	0	0	0	176,377	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	171,400	0	4,496,829	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
		NEW BLDG & FIXT	NEW CAP RELATED IRC	NEW MVBLE EQUIP	MVBLE EQUIP IRC	
	0	1.00	1.01	2.00	2.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	2,769,441	2,769,441			1.00
1.01 00101	NEW CAP RELATED IRC	346,171	0	346,171		1.01
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	2,254,516			2,254,516	2.00
2.01 00201	CAP REL COSTS-MVBLE EQUIP IRC	0			0	2.01
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	3,244,212	6,771	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	13,465,148	649,913	0	56,290	5.00
7.00 00700	OPERATION OF PLANT	2,915,236	262,734	0	63,053	7.00
7.01 00701	OPERATION OF PLANT IRC	0	0	14,812	0	7.01
8.00 00800	LAUNDRY & LINEN SERVICE	69,843	28,947	1,195	0	8.00
9.00 00900	HOUSEKEEPING	541,835	13,204	2,615	5,691	9.00
10.00 01000	DIETARY	497,092	63,855	0	6,519	10.00
11.00 01100	CAFETERIA	0	35,452	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	781,425	8,730	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	843,753	80,867	0	88,770	14.00
15.00 01500	PHARMACY	1,696,638	56,104	0	115,364	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	971,462	33,276	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	13,349	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	5,922,867	520,100	0	232,474	30.00
31.00 03100	INTENSIVE CARE UNIT	949,506	45,222	0	30,569	31.00
43.00 04300	NURSERY	349,884	26,226	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY	4,076,683	0	197,645	0	44.00
45.00 04500	NURSING FACILITY	536,671	0	95,220	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	2,422,055	194,756	0	245,138	50.00
53.00 05300	ANESTHESIOLOGY	43,693	0	0	78,233	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,064,370	107,106	0	349,547	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	246,737	0	0	71,267	55.00
57.00 05700	CT SCAN	209,980	0	0	6,212	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	181,016	2,201	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	790,275	29,116	0	261,698	59.00
60.00 06000	LABORATORY	5,210,720	170,066	0	178,196	60.00
65.00 06500	RESPIRATORY THERAPY	1,349,101	34,001	0	129,912	65.00
66.00 06600	PHYSICAL THERAPY	2,206,427	40,942	26,673	25,191	66.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,737,734	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	3,608,342	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2,759,838	0	0	0	73.00
76.00 03020	CARDIAC REHAB	554,327	105,195	0	15,972	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	102,123	0	0	2,569	90.00
90.01 09001	WOUND CENTER	105,897	20,567	0	3,838	90.01
91.00 09100	EMERGENCY	2,220,567	106,840	0	73,362	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	1,881,716	85,861	0	213,946	95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	68,927,301	2,741,401	338,160	2,253,811	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	45,689	19,286	2,338	633	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	190,556	8,754	0	72	192.00
192.01 19201	NONREIMBURSABLE	322,775	0	5,673	0	192.01
194.00 07950	CROSSTOWN SQUARE	629,920	0	0	0	194.00
194.02 07952	NONALLOWABLE PHYSICIAN	1,046,034	0	0	0	194.02
194.03 07953	NONALLOWABLE GUEST MEALS	695,560	0	0	0	194.03
194.04 07951	OUTREACH	185,437	0	0	0	194.04
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	72,043,272	2,769,441	346,171	2,254,516	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet B
Part I
Date/Time Prepared:
11/22/2013 8:42 am

Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT IRC	
		4.00	4A	5.00	7.00	7.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP RELATED IRC					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,250,983				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	133,634	14,304,985	14,304,985		5.00
7.00	00700	OPERATION OF PLANT	112,503	3,353,526	830,856	4,184,382	7.00
7.01	00701	OPERATION OF PLANT IRC	0	14,812	3,670	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	3,814	103,799	25,717	72,783	67 8.00
9.00	00900	HOUSEKEEPING	55,348	618,693	153,285	33,199	146 9.00
10.00	01000	DIETARY	14,638	582,104	144,220	160,554	0 10.00
11.00	01100	CAFETERIA	0	35,452	8,783	89,139	0 11.00
13.00	01300	NURSING ADMINISTRATION	80,424	870,579	215,691	21,950	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,887	1,023,277	253,523	203,330	0 14.00
15.00	01500	PHARMACY	166,984	2,035,090	504,206	48,127	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,004,738	248,930	83,667	0 16.00
17.00	01700	SOCIAL SERVICE	0	13,349	3,307	33,564	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	578,508	7,253,949	1,797,187	1,307,725	0 30.00
31.00	03100	INTENSIVE CARE UNIT	93,172	1,118,469	277,107	113,704	0 31.00
43.00	04300	NURSERY	33,919	410,029	101,587	65,942	0 43.00
44.00	04400	SKILLED NURSING FACILITY	346,652	4,620,980	1,144,876	0	11,024 44.00
45.00	04500	NURSING FACILITY	43,005	674,896	167,210	0	5,311 45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	163,545	3,025,494	749,584	489,689	0 50.00
53.00	05300	ANESTHESIOLOGY	24	121,950	30,214	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	108,183	1,629,206	403,646	269,303	0 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	10,117	328,121	81,294	0	0 55.00
57.00	05700	CT SCAN	19,104	235,296	58,296	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	8,789	192,006	47,571	5,533	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	41,996	1,123,085	278,251	73,209	0 59.00
60.00	06000	LABORATORY	239,005	5,797,987	1,436,486	241,120	0 60.00
65.00	06500	RESPIRATORY THERAPY	127,316	1,640,330	406,402	85,491	0 65.00
66.00	06600	PHYSICAL THERAPY	224,189	2,523,422	625,193	0	1,488 66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,737,734	430,534	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,608,342	893,988	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,759,838	683,766	0	0 73.00
76.00	03020	CARDIAC REHAB	45,449	720,943	178,618	179,616	0 76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	10,885	115,577	28,635	0	0 90.00
90.01	09001	WOUND CENTER	4,106	134,408	33,300	51,714	0 90.01
91.00	09100	EMERGENCY	209,963	2,610,732	646,825	268,634	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			0 92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	232,575	2,414,098	598,107	215,886	0 95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,117,734	68,757,296	13,490,865	4,113,879	18,036 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	623	68,569	16,988	48,492	130 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	832	200,214	49,604	22,011	0 192.00
192.01	19201	NONREIMBURSABLE	1,265	329,713	81,688	0	316 192.01
194.00	07950	CROSSTOWN SQUARE	32,379	662,299	164,089	0	0 194.00
194.02	07952	NONALLOWABLE PHYSICIAN	47,714	1,093,748	270,983	0	0 194.02
194.03	07953	NONALLOWABLE GUEST MEALS	31,727	727,287	180,190	0	0 194.03
194.04	07951	OUTREACH	18,709	204,146	50,578	0	0 194.04
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)	3,250,983	72,043,272	14,304,985	4,184,382	18,482 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

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Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP RELATED IRC					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT IRC					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	202,366				8.00
9.00	00900	HOUSEKEEPING	0	805,323			9.00
10.00	01000	DIETARY	0	30,509	917,387		10.00
11.00	01100	CAFETERIA	0	16,938	652,240	802,552	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,171	0	18,547	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,451	38,637	0	5,100	14.00
15.00	01500	PHARMACY	0	9,145	0	28,977	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15,898	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	6,378	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	33,803	248,496	250,352	168,005	30.00
31.00	03100	INTENSIVE CARE UNIT	4,531	21,606	14,795	22,836	31.00
43.00	04300	NURSERY	12,653	12,530	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	65,893	0	0	122,103	44.00
45.00	04500	NURSING FACILITY	5,973	0	0	16,994	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	30,003	93,051	0	37,324	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,104	51,173	0	28,430	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	1,941	55.00
57.00	05700	CT SCAN	4,224	0	0	4,394	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	848	1,051	0	1,871	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,978	13,911	0	6,706	59.00
60.00	06000	LABORATORY	30	45,818	0	76,131	60.00
65.00	06500	RESPIRATORY THERAPY	1,634	16,245	0	34,430	65.00
66.00	06600	PHYSICAL THERAPY	1,734	23,334	0	55,836	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED 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
76.00	03020	CARDIAC REHAB	1,276	34,131	0	12,053	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	3,212	90.00
90.01	09001	WOUND CENTER	0	9,827	0	1,447	90.01
91.00	09100	EMERGENCY	26,760	51,046	0	49,978	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	41,023	0	87,372	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	201,895	784,918	917,387	783,687	1,130,938
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,260	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	471	4,183	0	353	192.00
192.01	19201	NONREIMBURSABLE	0	4,962	0	582	192.01
194.00	07950	CROSSTOWN SQUARE	0	0	0	8,347	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	194.03
194.04	07951	OUTREACH	0	0	0	9,583	194.04
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)	202,366	805,323	917,387	802,552	1,130,938

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140275

Period:
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To 06/30/2013

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Cost Center Description			CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT IRC						7.01
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	1,525,509					14.00
15.00	01500	PHARMACY	5,716	2,631,261				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,353,233			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	56,598		17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	61,204	0	118,532	34,022	11,883,500	30.00
31.00	03100	INTENSIVE CARE UNIT	11,799	0	24,356	1,243	1,710,925	31.00
43.00	04300	NURSERY	0	0	6,670	3,542	612,953	43.00
44.00	04400	SKILLED NURSING FACILITY	18,208	0	27,029	0	6,010,113	44.00
45.00	04500	NURSING FACILITY	315	0	33,759	0	904,458	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	100,536	0	99,582	17,791	4,788,301	50.00
53.00	05300	ANESTHESIOLOGY	5,742	0	15,783	0	173,689	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,758	0	59,089	0	2,452,824	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	25,405	0	13,387	0	451,190	55.00
57.00	05700	CT SCAN	4,262	0	83,878	0	390,422	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	318	0	19,120	0	268,330	58.00
59.00	05900	CARDIAC CATHETERIZATION	18,956	0	58,799	0	1,590,025	59.00
60.00	06000	LABORATORY	265,224	0	181,551	0	8,054,155	60.00
65.00	06500	RESPIRATORY THERAPY	16,778	0	100,614	0	2,303,065	65.00
66.00	06600	PHYSICAL THERAPY	2,988	0	52,460	0	3,286,455	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	306,456	0	35,067	0	2,509,791	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	636,350	0	87,816	0	5,226,496	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,631,261	114,234	0	6,189,099	73.00
76.00	03020	CARDIAC REHAB	610	0	4,983	0	1,159,777	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1	0	664	0	148,089	90.00
90.01	09001	WOUND CENTER	1,122	0	2,510	0	239,137	90.01
91.00	09100	EMERGENCY	31,256	0	167,849	0	4,067,930	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	9,370	0	45,501	0	3,411,627	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,525,374	2,631,261	1,353,233	56,598	67,832,351	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	145,439	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	276,836	192.00
192.01	19201	NONREIMBURSABLE	0	0	0	0	417,261	192.01
194.00	07950	CROSSTOWN SQUARE	0	0	0	0	834,735	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	0	1,364,731	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	907,477	194.03
194.04	07951	OUTREACH	135	0	0	0	264,442	194.04
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)	1,525,509	2,631,261	1,353,233	56,598	72,043,272	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

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Part I
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	NEW CAP RELATED IRC		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
7.01	00701	OPERATION OF PLANT IRC		7.01
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
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	11,883,500
31.00	03100	INTENSIVE CARE UNIT	0	1,710,925
43.00	04300	NURSERY	0	612,953
44.00	04400	SKILLED NURSING FACILITY	0	6,010,113
45.00	04500	NURSING FACILITY	0	904,458
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	4,788,301
53.00	05300	ANESTHESIOLOGY	0	173,689
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,452,824
55.00	05500	RADIOLOGY-THERAPEUTIC	0	451,190
57.00	05700	CT SCAN	0	390,422
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	268,330
59.00	05900	CARDIAC CATHETERIZATION	0	1,590,025
60.00	06000	LABORATORY	0	8,054,155
65.00	06500	RESPIRATORY THERAPY	0	2,303,065
66.00	06600	PHYSICAL THERAPY	0	3,286,455
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,509,791
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	5,226,496
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,189,099
76.00	03020	CARDIAC REHAB	0	1,159,777
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	148,089
90.01	09001	WOUND CENTER	0	239,137
91.00	09100	EMERGENCY	0	4,067,930
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	3,411,627
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	67,832,351
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	145,439
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	276,836
192.01	19201	NONREIMBURSABLE	0	417,261
194.00	07950	CROSSTOWN SQUARE	0	834,735
194.02	07952	NONALLOWABLE PHYSICIAN	0	1,364,731
194.03	07953	NONALLOWABLE GUEST MEALS	0	907,477
194.04	07951	OUTREACH	0	264,442
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	72,043,272

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

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Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
		NEW BLDG & FIXT	NEW CAP RELATED IRC	NEW MVBLE EQUIP	MVBLE EQUIP IRC	
		1.00	1.01	2.00	2.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	NEW CAP RELATED IRC					1.01
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01 00201	CAP REL COSTS-MVBLE EQUIP IRC					2.01
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,771	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	283,218	649,913	0	56,290	5.00
7.00 00700	OPERATION OF PLANT	306,043	262,734	0	63,053	7.00
7.01 00701	OPERATION OF PLANT IRC	0	0	14,812	0	7.01
8.00 00800	LAUNDRY & LINEN SERVICE	15	28,947	1,195	0	8.00
9.00 00900	HOUSEKEEPING	2,728	13,204	2,615	5,691	9.00
10.00 01000	DIETARY	3,995	63,855	0	6,519	10.00
11.00 01100	CAFETERIA	0	35,452	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	6,610	8,730	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	75,525	80,867	0	88,770	14.00
15.00 01500	PHARMACY	72,345	56,104	0	115,364	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	33,276	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	13,349	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	46,360	520,100	0	232,474	30.00
31.00 03100	INTENSIVE CARE UNIT	1,925	45,222	0	30,569	31.00
43.00 04300	NURSERY	0	26,226	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY	29,200	0	197,645	0	44.00
45.00 04500	NURSING FACILITY	0	0	95,220	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	51,689	194,756	0	245,138	50.00
53.00 05300	ANESTHESIOLOGY	7,651	0	0	78,233	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	8,118	107,106	0	349,547	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	2,916	0	0	71,267	55.00
57.00 05700	CT SCAN	4,610	0	0	6,212	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	28,684	2,201	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	33,621	29,116	0	261,698	59.00
60.00 06000	LABORATORY	146,781	170,066	0	178,196	60.00
65.00 06500	RESPIRATORY THERAPY	46,542	34,001	0	129,912	65.00
66.00 06600	PHYSICAL THERAPY	175,241	40,942	26,673	25,191	66.00
71.00 07100	MEDICAL SUPPLIES CHARGED 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
76.00 03020	CARDIAC REHAB	125,417	105,195	0	15,972	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	1,478	0	0	2,569	90.00
90.01 09001	WOUND CENTER	26,988	20,567	0	3,838	90.01
91.00 09100	EMERGENCY	12,654	106,840	0	73,362	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	113,355	85,861	0	213,946	95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,613,709	2,741,401	338,160	2,253,811	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,286	2,338	633	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	102,582	8,754	0	72	192.00
192.01 19201	NONREIMBURSABLE	126,234	0	5,673	0	192.01
194.00 07950	CROSSTOWN SQUARE	2,583	0	0	0	194.00
194.02 07952	NONALLOWABLE PHYSICIAN	0	0	0	0	194.02
194.03 07953	NONALLOWABLE GUEST MEALS	0	0	0	0	194.03
194.04 07951	OUTREACH	0	0	0	0	194.04
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,845,108	2,769,441	346,171	2,254,516	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet B
Part II
Date/Time Prepared:
11/22/2013 8:42 am

Cost Center Description		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT IRC	
		2A	4.00	5.00	7.00	7.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP RELATED IRC					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,771	6,771			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	989,421	278	989,699		5.00
7.00	00700	OPERATION OF PLANT	631,830	234	57,483	689,547	7.00
7.01	00701	OPERATION OF PLANT IRC	14,812	0	254	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	30,157	8	1,779	11,994	54
9.00	00900	HOUSEKEEPING	24,238	115	10,605	5,471	119
10.00	01000	DIETARY	74,369	30	9,978	26,458	0
11.00	01100	CAFETERIA	35,452	0	608	14,689	0
13.00	01300	NURSING ADMINISTRATION	15,340	167	14,923	3,617	0
14.00	01400	CENTRAL SERVICES & SUPPLY	245,162	21	17,540	33,507	0
15.00	01500	PHARMACY	243,813	348	34,883	7,931	0
16.00	01600	MEDICAL RECORDS & LIBRARY	33,276	0	17,222	13,788	0
17.00	01700	SOCIAL SERVICE	13,349	0	229	5,531	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	798,934	1,207	124,349	215,501	0
31.00	03100	INTENSIVE CARE UNIT	77,716	194	19,172	18,737	0
43.00	04300	NURSERY	26,226	71	7,028	10,867	0
44.00	04400	SKILLED NURSING FACILITY	226,845	722	79,208	0	8,987
45.00	04500	NURSING FACILITY	95,220	90	11,568	0	4,329
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	491,583	340	51,860	80,696	0
53.00	05300	ANESTHESIOLOGY	85,884	0	2,090	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	464,771	225	27,926	44,379	0
55.00	05500	RADIOLOGY-THERAPEUTIC	74,183	21	5,624	0	0
57.00	05700	CT SCAN	10,822	40	4,033	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	30,885	18	3,291	912	0
59.00	05900	CARDIAC CATHETERIZATION	324,435	87	19,251	12,064	0
60.00	06000	LABORATORY	495,043	498	99,383	39,734	0
65.00	06500	RESPIRATORY THERAPY	210,455	265	28,117	14,088	0
66.00	06600	PHYSICAL THERAPY	268,047	467	43,254	0	1,213
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	29,786	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	61,851	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	47,306	0	0
76.00	03020	CARDIAC REHAB	246,584	95	12,358	29,599	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	4,047	23	1,981	0	0
90.01	09001	WOUND CENTER	51,393	9	2,304	8,522	0
91.00	09100	EMERGENCY	192,856	437	44,751	44,268	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0				0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	413,162	484	41,380	35,576	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,947,081	6,494	933,375	677,929	14,702
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	22,257	1	1,175	7,991	106
192.00	19200	PHYSICIANS' PRIVATE OFFICES	111,408	2	3,432	3,627	0
192.01	19201	NONREIMBURSABLE	131,907	3	5,652	0	258
194.00	07950	CROSSTOWN SQUARE	2,583	67	11,352	0	0
194.02	07952	NONALLOWABLE PHYSICIAN	0	99	18,748	0	0
194.03	07953	NONALLOWABLE GUEST MEALS	0	66	12,466	0	0
194.04	07951	OUTREACH	0	39	3,499	0	0
200.00		Cross Foot Adjustments	0				200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	7,215,236	6,771	989,699	689,547	15,066

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet B
Part II
Date/Time Prepared:
11/22/2013 8:42 am

Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP RELATED IRC					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT IRC					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	43,992				8.00
9.00	00900	HOUSEKEEPING	0	40,548			9.00
10.00	01000	DIETARY	0	1,536	112,371		10.00
11.00	01100	CAFETERIA	0	853	79,893	131,495	11.00
13.00	01300	NURSING ADMINISTRATION	0	210	0	3,039	37,296
14.00	01400	CENTRAL SERVICES & SUPPLY	315	1,945	0	836	6
15.00	01500	PHARMACY	0	460	0	4,748	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	800	0	0	0
17.00	01700	SOCIAL SERVICE	0	321	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,348	12,512	30,666	27,526	20,125
31.00	03100	INTENSIVE CARE UNIT	985	1,088	1,812	3,742	3,314
43.00	04300	NURSERY	2,751	631	0	0	0
44.00	04400	SKILLED NURSING FACILITY	14,326	0	0	20,006	0
45.00	04500	NURSING FACILITY	1,299	0	0	2,784	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,522	4,685	0	6,115	4,790
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,979	2,577	0	4,658	4
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	318	34
57.00	05700	CT SCAN	918	0	0	720	2
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	184	53	0	306	0
59.00	05900	CARDIAC CATHETERIZATION	430	700	0	1,099	499
60.00	06000	LABORATORY	7	2,307	0	12,474	323
65.00	06500	RESPIRATORY THERAPY	355	818	0	5,641	38
66.00	06600	PHYSICAL THERAPY	377	1,175	0	9,149	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03020	CARDIAC REHAB	277	1,718	0	1,975	908
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	526	0
90.01	09001	WOUND CENTER	0	495	0	237	159
91.00	09100	EMERGENCY	5,817	2,570	0	8,189	7,085
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	2,066	0	14,316	9
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	43,890	39,520	112,371	128,404	37,296
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	567	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	102	211	0	58	0
192.01	19201	NONREIMBURSABLE	0	250	0	95	0
194.00	07950	CROSSTOWN SQUARE	0	0	0	1,368	0
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	0	0
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	0
194.04	07951	OUTREACH	0	0	0	1,570	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	43,992	40,548	112,371	131,495	37,296

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140275	Period: From 07/01/2012 To 06/30/2013	Worksheet B Part II Date/Time Prepared: 11/22/2013 8:42 am
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Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
		14.00	15.00	16.00	17.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP RELATED IRC					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT IRC					7.01
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	299,332				14.00
15.00	01500	PHARMACY	1,122				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	293,305	65,086		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	19,430	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,009	0	5,694	11,680	1,267,551
31.00	03100	INTENSIVE CARE UNIT	2,315	0	1,170	427	130,672
43.00	04300	NURSERY	0	0	320	1,216	49,110
44.00	04400	SKILLED NURSING FACILITY	3,573	0	1,298	0	354,965
45.00	04500	NURSING FACILITY	62	0	1,622	0	116,974
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	19,727	0	4,783	6,107	677,208
53.00	05300	ANESTHESIOLOGY	1,127	0	758	0	89,859
54.00	05400	RADIOLOGY-DIAGNOSTIC	541	0	2,838	0	549,898
55.00	05500	RADIOLOGY-THERAPEUTIC	4,985	0	643	0	85,808
57.00	05700	CT SCAN	836	0	4,029	0	21,400
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	62	0	918	0	36,629
59.00	05900	CARDIAC CATHETERIZATION	3,720	0	2,824	0	365,109
60.00	06000	LABORATORY	52,042	0	8,806	0	710,617
65.00	06500	RESPIRATORY THERAPY	3,292	0	4,833	0	267,902
66.00	06600	PHYSICAL THERAPY	586	0	2,520	0	326,788
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	60,133	0	1,684	0	91,603
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	124,861	0	4,218	0	190,930
73.00	07300	DRUGS CHARGED TO PATIENTS	0	293,305	5,487	0	346,098
76.00	03020	CARDIAC REHAB	120	0	239	0	293,873
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	32	0	6,609
90.01	09001	WOUND CENTER	220	0	121	0	63,460
91.00	09100	EMERGENCY	6,133	0	8,063	0	320,169
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,839	0	2,186	0	511,018
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	299,305	293,305	65,086	19,430	6,874,250
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	32,097
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	118,840
192.01	19201	NONREIMBURSABLE	0	0	0	0	138,165
194.00	07950	CROSSTOWN SQUARE	0	0	0	0	15,370
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	0	18,847
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	12,532
194.04	07951	OUTREACH	27	0	0	0	5,135
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	299,332	293,305	65,086	19,430	7,215,236

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet B
Part II
Date/Time Prepared:
11/22/2013 8:42 am

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	NEW CAP RELATED IRC		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
7.01	00701	OPERATION OF PLANT IRC		7.01
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
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,267,551
31.00	03100	INTENSIVE CARE UNIT	0	130,672
43.00	04300	NURSERY	0	49,110
44.00	04400	SKILLED NURSING FACILITY	0	354,965
45.00	04500	NURSING FACILITY	0	116,974
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	677,208
53.00	05300	ANESTHESIOLOGY	0	89,859
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	549,898
55.00	05500	RADIOLOGY-THERAPEUTIC	0	85,808
57.00	05700	CT SCAN	0	21,400
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	36,629
59.00	05900	CARDIAC CATHETERIZATION	0	365,109
60.00	06000	LABORATORY	0	710,617
65.00	06500	RESPIRATORY THERAPY	0	267,902
66.00	06600	PHYSICAL THERAPY	0	326,788
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	91,603
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	190,930
73.00	07300	DRUGS CHARGED TO PATIENTS	0	346,098
76.00	03020	CARDIAC REHAB	0	293,873
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	6,609
90.01	09001	WOUND CENTER	0	63,460
91.00	09100	EMERGENCY	0	320,169
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	511,018
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	6,874,250
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	32,097
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	118,840
192.01	19201	NONREIMBURSABLE	0	138,165
194.00	07950	CROSSTOWN SQUARE	0	15,370
194.02	07952	NONALLOWABLE PHYSICIAN	0	18,847
194.03	07953	NONALLOWABLE GUEST MEALS	0	12,532
194.04	07951	OUTREACH	0	5,135
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	7,215,236

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet B-1

Date/Time Prepared:
11/22/2013 8:42 am

Cost Center Description	CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW CAP RELATED IRC (SQUARE FEET IRC)	NEW MVBLE EQUIP (DOLLAR VALUE)	MVBLE EQUIP IRC (DOLLAR VALUE)		
	1.00	1.01	2.00	2.01		
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	229,042				1.00
1.01 00101	NEW CAP RELATED IRC	0	52,420			1.01
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP			2,061,169		2.00
2.01 00201	CAP REL COSTS-MVBLE EQUIP IRC			0	0	2.01
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	560	0	0	0	27,853,406
5.00 00500	ADMINISTRATIVE & GENERAL	53,750	0	51,463	0	1,144,933
7.00 00700	OPERATION OF PLANT	21,729	0	57,646	0	963,890
7.01 00701	OPERATION OF PLANT IRC	0	2,243	0	0	0
8.00 00800	LAUNDRY & LINEN SERVICE	2,394	181	0	0	32,674
9.00 00900	HOUSEKEEPING	1,092	396	5,203	0	474,207
10.00 01000	DIETARY	5,281	0	5,960	0	125,417
11.00 01100	CAFETERIA	2,932	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	722	0	0	0	689,047
14.00 01400	CENTRAL SERVICES & SUPPLY	6,688	0	81,157	0	84,705
15.00 01500	PHARMACY	4,640	0	105,470	0	1,430,664
16.00 01600	MEDICAL RECORDS & LIBRARY	2,752	0	0	0	0
17.00 01700	SOCIAL SERVICE	1,104	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	43,014	0	212,537	0	4,956,533
31.00 03100	INTENSIVE CARE UNIT	3,740	0	27,947	0	798,264
43.00 04300	NURSERY	2,169	0	0	0	290,605
44.00 04400	SKILLED NURSING FACILITY	0	29,929	0	0	2,969,998
45.00 04500	NURSING FACILITY	0	14,419	0	0	368,450
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	16,107	0	224,115	0	1,401,201
53.00 05300	ANESTHESIOLOGY	0	0	71,524	0	204
54.00 05400	RADIOLOGY-DIAGNOSTIC	8,858	0	319,569	0	926,877
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	65,155	0	86,675
57.00 05700	CT SCAN	0	0	5,679	0	163,673
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	182	0	0	0	75,299
59.00 05900	CARDIAC CATHETERIZATION	2,408	0	239,255	0	359,809
60.00 06000	LABORATORY	14,065	0	162,914	0	2,047,713
65.00 06500	RESPIRATORY THERAPY	2,812	0	118,771	0	1,090,804
66.00 06600	PHYSICAL THERAPY	3,386	4,039	23,031	0	1,920,776
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00 03020	CARDIAC REHAB	8,700	0	14,602	0	389,393
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	2,349	0	93,262
90.01 09001	WOUND CENTER	1,701	0	3,509	0	35,181
91.00 09100	EMERGENCY	8,836	0	67,070	0	1,798,889
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	7,101	0	195,598	0	1,992,623
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	226,723	51,207	2,060,524	0	26,711,766
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,595	354	579	0	5,339
192.00 19200	PHYSICIANS' PRIVATE OFFICES	724	0	66	0	7,125
192.01 19201	NONREIMBURSABLE	0	859	0	0	10,842
194.00 07950	CROSSTOWN SQUARE	0	0	0	0	277,416
194.02 07952	NONALLOWABLE PHYSICIAN	0	0	0	0	408,798
194.03 07953	NONALLOWABLE GUEST MEALS	0	0	0	0	271,830
194.04 07951	OUTREACH	0	0	0	0	160,290
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	2,769,441	346,171	2,254,516	0	3,250,983
203.00	Unit cost multiplier (Wkst. B, Part I)	12.091411	6.603796	1.093805	0.000000	0.116718
204.00	Cost to be allocated (per Wkst. B, Part II)					6,771
205.00	Unit cost multiplier (Wkst. B, Part II)					0.000243

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140275

Period: 07/01/2012
To 06/30/2013

Worksheet B-1

Date/Time Prepared: 11/22/2013 8:42 am

Cost Center Description		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT IRC (SQUARE FEET IRC)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		5A	5.00	7.00	7.01	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP RELATED IRC					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-14,304,985	57,738,287			5.00
7.00	00700	OPERATION OF PLANT	0	3,353,526	137,634		7.00
7.01	00701	OPERATION OF PLANT IRC	0	14,812	0	50,177	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	103,799	2,394	181	713,947
9.00	00900	HOUSEKEEPING	0	618,693	1,092	396	0
10.00	01000	DIETARY	0	582,104	5,281	0	0
11.00	01100	CAFETERIA	0	35,452	2,932	0	0
13.00	01300	NURSING ADMINISTRATION	0	870,579	722	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,023,277	6,688	0	5,118
15.00	01500	PHARMACY	0	2,035,090	1,583	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,004,738	2,752	0	0
17.00	01700	SOCIAL SERVICE	0	13,349	1,104	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	7,253,949	43,014	0	119,258
31.00	03100	INTENSIVE CARE UNIT	0	1,118,469	3,740	0	15,987
43.00	04300	NURSERY	0	410,029	2,169	0	44,638
44.00	04400	SKILLED NURSING FACILITY	0	4,620,980	0	29,929	232,465
45.00	04500	NURSING FACILITY	0	674,896	0	14,419	21,074
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	3,025,494	16,107	0	105,850
53.00	05300	ANESTHESIOLOGY	0	121,950	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,629,206	8,858	0	32,119
55.00	05500	RADIOLOGY-THERAPEUTIC	0	328,121	0	0	0
57.00	05700	CT SCAN	0	235,296	0	0	14,902
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	192,006	182	0	2,993
59.00	05900	CARDIAC CATHETERIZATION	0	1,123,085	2,408	0	6,980
60.00	06000	LABORATORY	0	5,797,987	7,931	0	107
65.00	06500	RESPIRATORY THERAPY	0	1,640,330	2,812	0	5,764
66.00	06600	PHYSICAL THERAPY	0	2,523,422	0	4,039	6,119
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,737,734	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,608,342	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,759,838	0	0	0
76.00	03020	CARDIAC REHAB	0	720,943	5,908	0	4,502
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	115,577	0	0	0
90.01	09001	WOUND CENTER	0	134,408	1,701	0	0
91.00	09100	EMERGENCY	0	2,610,732	8,836	0	94,408
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	2,414,098	7,101	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-14,304,985	54,452,311	135,315	48,964	712,284
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	68,569	1,595	354	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	200,214	724	0	1,663
192.01	19201	NONREIMBURSABLE	0	329,713	0	859	0
194.00	07950	CROSSTOWN SQUARE	0	662,299	0	0	0
194.02	07952	NONALLOWABLE PHYSICIAN	0	1,093,748	0	0	0
194.03	07953	NONALLOWABLE GUEST MEALS	0	727,287	0	0	0
194.04	07951	OUTREACH	0	204,146	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	14,304,985	4,184,382	18,482	202,366	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.247756	30.402241	0.368336	0.283447	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	989,699	689,547	15,066	43,992	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.017141	5.010005	0.300257	0.061618	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet B-1

Date/Time Prepared:
11/22/2013 8:42 am

Cost Center Description		HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
7.01	00701						7.01
8.00	00800						8.00
9.00	00900	139,400					9.00
10.00	01000	5,281	149,500				10.00
11.00	01100	2,932	106,291	45,477			11.00
13.00	01300	722	0	1,051	284,348		13.00
14.00	01400	6,688	0	289	48	8,650,251	14.00
15.00	01500	1,583	0	1,642	0	32,411	15.00
16.00	01600	2,752	0	0	0	0	16.00
17.00	01700	1,104	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	43,014	40,798	9,520	153,427	347,052	30.00
31.00	03100	3,740	2,411	1,294	25,263	66,904	31.00
43.00	04300	2,169	0	0	0	0	43.00
44.00	04400	0	0	6,919	0	103,246	44.00
45.00	04500	0	0	963	0	1,787	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	16,107	0	2,115	36,519	570,083	50.00
53.00	05300	0	0	0	0	32,557	53.00
54.00	05400	8,858	0	1,611	29	15,640	54.00
55.00	05500	0	0	110	262	144,057	55.00
57.00	05700	0	0	249	18	24,168	57.00
58.00	05800	182	0	106	3	1,803	58.00
59.00	05900	2,408	0	380	3,804	107,491	59.00
60.00	06000	7,931	0	4,314	2,466	1,503,932	60.00
65.00	06500	2,812	0	1,951	287	95,137	65.00
66.00	06600	4,039	0	3,164	0	16,944	66.00
71.00	07100	0	0	0	0	1,737,734	71.00
72.00	07200	0	0	0	0	3,608,342	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03020	5,908	0	683	6,926	3,459	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	182	0	6	90.00
90.01	09001	1,701	0	82	1,209	6,364	90.01
91.00	09100	8,836	0	2,832	54,019	177,234	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	7,101	0	4,951	68	53,134	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00							118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	1,949	0	0	0	0	190.00
192.00	19200	724	0	20	0	0	192.00
192.01	19201	859	0	33	0	0	192.01
194.00	07950	0	0	473	0	0	194.00
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07951	0	0	543	0	766	194.04
200.00							200.00
201.00							201.00
202.00		805,323	917,387	802,552	1,130,938	1,525,509	202.00
203.00		5.777066	6.136368	17.647426	3.977302	0.176354	203.00
204.00		40,548	112,371	131,495	37,296	299,332	204.00
205.00		0.290875	0.751645	2.891462	0.131163	0.034604	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet B-1
Date/Time Prepared:
11/22/2013 8:42 am

Cost Center Description		PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	
		15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
1.01	00101				1.01
2.00	00200				2.00
2.01	00201				2.01
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
7.01	00701				7.01
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500	2,759,838			15.00
16.00	01600	0	194,034,483		16.00
17.00	01700	0	0	7,877	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	0	16,996,297	4,735	30.00
31.00	03100	0	3,492,447	173	31.00
43.00	04300	0	956,481	493	43.00
44.00	04400	0	3,875,648	0	44.00
45.00	04500	0	4,840,699	0	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	0	14,279,031	2,476	50.00
53.00	05300	0	2,263,130	0	53.00
54.00	05400	0	8,472,714	0	54.00
55.00	05500	0	1,919,523	0	55.00
57.00	05700	0	12,027,188	0	57.00
58.00	05800	0	2,741,682	0	58.00
59.00	05900	0	8,431,119	0	59.00
60.00	06000	0	26,027,318	0	60.00
65.00	06500	0	14,427,040	0	65.00
66.00	06600	0	7,522,164	0	66.00
71.00	07100	0	5,028,277	0	71.00
72.00	07200	0	12,591,917	0	72.00
73.00	07300	2,759,838	16,379,966	0	73.00
76.00	03020	0	714,486	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	0	95,279	0	90.00
90.01	09001	0	359,898	0	90.01
91.00	09100	0	24,067,797	0	91.00
92.00	09200				92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	0	6,524,382	0	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		2,759,838	194,034,483	7,877	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	0	0	0	190.00
192.00	19200	0	0	0	192.00
192.01	19201	0	0	0	192.01
194.00	07950	0	0	0	194.00
194.02	07952	0	0	0	194.02
194.03	07953	0	0	0	194.03
194.04	07951	0	0	0	194.04
200.00					200.00
201.00					201.00
202.00		2,631,261	1,353,233	56,598	202.00
203.00		0.953411	0.006974	7.185223	203.00
204.00		293,305	65,086	19,430	204.00
205.00		0.106276	0.000335	2.466675	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140275	Period: From 07/01/2012 To 06/30/2013	Worksheet C Part I Date/Time Prepared: 11/22/2013 8:42 am
		Title XVIII	Hospital	PPS

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	11,883,500		11,883,500	0	11,883,500	30.00
31.00 03100 INTENSIVE CARE UNIT	1,710,925		1,710,925	0	1,710,925	31.00
43.00 04300 NURSERY	612,953		612,953	0	612,953	43.00
44.00 04400 SKILLED NURSING FACILITY	6,010,113		6,010,113	0	6,010,113	44.00
45.00 04500 NURSING FACILITY	904,458		904,458	0	904,458	45.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	4,788,301		4,788,301	0	4,788,301	50.00
53.00 05300 ANESTHESIOLOGY	173,689		173,689	0	173,689	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,452,824		2,452,824	0	2,452,824	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	451,190		451,190	0	451,190	55.00
57.00 05700 CT SCAN	390,422		390,422	0	390,422	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	268,330		268,330	0	268,330	58.00
59.00 05900 CARDIAC CATHETERIZATION	1,590,025		1,590,025	0	1,590,025	59.00
60.00 06000 LABORATORY	8,054,155		8,054,155	0	8,054,155	60.00
65.00 06500 RESPIRATORY THERAPY	2,303,065	0	2,303,065	0	2,303,065	65.00
66.00 06600 PHYSICAL THERAPY	3,286,455	0	3,286,455	0	3,286,455	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,509,791		2,509,791	0	2,509,791	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	5,226,496		5,226,496	0	5,226,496	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	6,189,099		6,189,099	0	6,189,099	73.00
76.00 03020 CARDIAC REHAB	1,159,777		1,159,777	0	1,159,777	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	148,089		148,089	0	148,089	90.00
90.01 09001 WOUND CENTER	239,137		239,137	0	239,137	90.01
91.00 09100 EMERGENCY	4,067,930		4,067,930	0	4,067,930	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,299,059		1,299,059	0	1,299,059	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	3,411,627		3,411,627	0	3,411,627	95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	0	69,131,410	0	69,131,410	200.00
201.00	Less Observation Beds		1,299,059		1,299,059	201.00
202.00	Total (see instructions)	0	67,832,351	0	67,832,351	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet C
Part I
Date/Time Prepared:
11/22/2013 8:42 am

		Title XVIII			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	16,996,297		16,996,297		30.00
31.00	03100	INTENSIVE CARE UNIT	3,492,447		3,492,447		31.00
43.00	04300	NURSERY	956,481		956,481		43.00
44.00	04400	SKILLED NURSING FACILITY	3,875,648		3,875,648		44.00
45.00	04500	NURSING FACILITY	4,840,699		4,840,699		45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,806,474	8,472,557	14,279,031	0.335338	50.00
53.00	05300	ANESTHESIOLOGY	903,059	1,360,071	2,263,130	0.076747	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,762,338	6,710,376	8,472,714	0.289497	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	226,074	1,693,449	1,919,523	0.235053	55.00
57.00	05700	CT SCAN	2,804,833	9,222,355	12,027,188	0.032462	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	400,121	2,341,561	2,741,682	0.097871	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,912,201	4,518,918	8,431,119	0.188590	59.00
60.00	06000	LABORATORY	7,506,541	18,520,777	26,027,318	0.309450	60.00
65.00	06500	RESPIRATORY THERAPY	9,076,916	5,350,124	14,427,040	0.159635	65.00
66.00	06600	PHYSICAL THERAPY	4,340,467	3,181,697	7,522,164	0.436903	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,003,628	2,024,648	5,028,276	0.499135	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,127,982	4,463,935	12,591,917	0.415068	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,893,292	6,486,674	16,379,966	0.377846	73.00
76.00	03020	CARDIAC REHAB	14,818	699,668	714,486	1.623233	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	5,804	89,475	95,279	1.554267	90.00
90.01	09001	WOUND CENTER	1,160	358,738	359,898	0.664458	90.01
91.00	09100	EMERGENCY	4,674,396	19,393,401	24,067,797	0.169020	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	209,410	1,555,896	1,765,306	0.735883	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	6,524,382	6,524,382	0.522904	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	92,831,086	102,968,702	195,799,788		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	92,831,086	102,968,702	195,799,788		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140275	Period: From 07/01/2012 To 06/30/2013	Worksheet C Part I Date/Time Prepared: 11/22/2013 8:42 am
		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
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
45.00	04500 NURSING FACILITY			45.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.335338		50.00
53.00	05300 ANESTHESIOLOGY	0.076747		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.289497		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.235053		55.00
57.00	05700 CT SCAN	0.032462		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.097871		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.188590		59.00
60.00	06000 LABORATORY	0.309450		60.00
65.00	06500 RESPIRATORY THERAPY	0.159635		65.00
66.00	06600 PHYSICAL THERAPY	0.436903		66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.499135		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.415068		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.377846		73.00
76.00	03020 CARDIAC REHAB	1.623233		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	1.554267		90.00
90.01	09001 WOUND CENTER	0.664458		90.01
91.00	09100 EMERGENCY	0.169020		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.735883		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.522904		95.00
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: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet C
Part I
Date/Time Prepared:
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		Title XIX		Hospital		Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	11,883,500		11,883,500	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	1,710,925		1,710,925	0	0	31.00
43.00	04300 NURSERY	612,953		612,953	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	6,010,113		6,010,113	0	0	44.00
45.00	04500 NURSING FACILITY	904,458		904,458	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	4,788,301		4,788,301	0	0	50.00
53.00	05300 ANESTHESIOLOGY	173,689		173,689	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,452,824		2,452,824	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	451,190		451,190	0	0	55.00
57.00	05700 CT SCAN	390,422		390,422	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	268,330		268,330	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	1,590,025		1,590,025	0	0	59.00
60.00	06000 LABORATORY	8,054,155		8,054,155	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	2,303,065	0	2,303,065	0	0	65.00
66.00	06600 PHYSICAL THERAPY	3,286,455	0	3,286,455	0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,509,791		2,509,791	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	5,226,496		5,226,496	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	6,189,099		6,189,099	0	0	73.00
76.00	03020 CARDIAC REHAB	1,159,777		1,159,777	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	148,089		148,089	0	0	90.00
90.01	09001 WOUND CENTER	239,137		239,137	0	0	90.01
91.00	09100 EMERGENCY	4,067,930		4,067,930	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,299,059		1,299,059	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	3,411,627		3,411,627	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	69,131,410	0	69,131,410	0	0	200.00
201.00	Less Observation Beds	1,299,059		1,299,059	0	0	201.00
202.00	Total (see instructions)	67,832,351	0	67,832,351	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

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Part I
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		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	16,996,297		16,996,297		30.00
31.00	03100	INTENSIVE CARE UNIT	3,492,447		3,492,447		31.00
43.00	04300	NURSERY	956,481		956,481		43.00
44.00	04400	SKILLED NURSING FACILITY	3,875,648		3,875,648		44.00
45.00	04500	NURSING FACILITY	4,840,699		4,840,699		45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,806,474	8,472,557	14,279,031	0.335338	50.00
53.00	05300	ANESTHESIOLOGY	903,059	1,360,071	2,263,130	0.076747	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,762,338	6,710,376	8,472,714	0.289497	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	226,074	1,693,449	1,919,523	0.235053	55.00
57.00	05700	CT SCAN	2,804,833	9,222,355	12,027,188	0.032462	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	400,121	2,341,561	2,741,682	0.097871	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,912,201	4,518,918	8,431,119	0.188590	59.00
60.00	06000	LABORATORY	7,506,541	18,520,777	26,027,318	0.309450	60.00
65.00	06500	RESPIRATORY THERAPY	9,076,916	5,350,124	14,427,040	0.159635	65.00
66.00	06600	PHYSICAL THERAPY	4,340,467	3,181,697	7,522,164	0.436903	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,003,628	2,024,648	5,028,276	0.499135	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,127,982	4,463,935	12,591,917	0.415068	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,893,292	6,486,674	16,379,966	0.377846	73.00
76.00	03020	CARDIAC REHAB	14,818	699,668	714,486	1.623233	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	5,804	89,475	95,279	1.554267	90.00
90.01	09001	WOUND CENTER	1,160	358,738	359,898	0.664458	90.01
91.00	09100	EMERGENCY	4,674,396	19,393,401	24,067,797	0.169020	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	209,410	1,555,896	1,765,306	0.735883	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	6,524,382	6,524,382	0.522904	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	92,831,086	102,968,702	195,799,788		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	92,831,086	102,968,702	195,799,788		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet C
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Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
43.00	04300 NURSERY				43.00
44.00	04400 SKILLED NURSING FACILITY				44.00
45.00	04500 NURSING FACILITY				45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000			55.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03020 CARDIAC REHAB	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
90.01	09001 WOUND CENTER	0.000000			90.01
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140275		Period: From 07/01/2012 To 06/30/2013		Worksheet D Part I Date/Time Prepared: 11/22/2013 8:42 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,267,551	0	1,267,551	13,246	95.69	30.00
31.00	INTENSIVE CARE UNIT	130,672		130,672	1,125	116.15	31.00
43.00	NURSERY	49,110		49,110	1,192	41.20	43.00
44.00	SKILLED NURSING FACILITY	354,965		354,965	22,773	15.59	44.00
45.00	NURSING FACILITY	116,974		116,974	11,643	10.05	45.00
200.00	Total (lines 30-199)	1,919,272		1,919,272	49,979		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	6,021	576,149				
31.00	INTENSIVE CARE UNIT	641	74,452				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	6,955	108,428				
45.00	NURSING FACILITY	0	0				
200.00	Total (lines 30-199)	13,617	759,029				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140275	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part II Date/Time Prepared: 11/22/2013 8:42 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	677,208	14,279,031	0.047427	2,136,040	101,306	50.00
53.00	05300 ANESTHESIOLOGY	89,859	2,263,130	0.039706	301,961	11,990	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	549,898	8,472,714	0.064902	841,432	54,611	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	85,808	1,919,523	0.044703	1,042	47	55.00
57.00	05700 CT SCAN	21,400	12,027,188	0.001779	984,197	1,751	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	36,629	2,741,682	0.013360	207,399	2,771	58.00
59.00	05900 CARDIAC CATHETERIZATION	365,109	8,431,119	0.043305	1,858,125	80,466	59.00
60.00	06000 LABORATORY	710,617	26,027,318	0.027303	3,300,721	90,120	60.00
65.00	06500 RESPIRATORY THERAPY	267,902	14,427,040	0.018569	5,178,425	96,158	65.00
66.00	06600 PHYSICAL THERAPY	326,788	7,522,164	0.043443	695,447	30,212	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	91,603	5,028,276	0.018218	1,556,562	28,357	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	190,930	12,591,917	0.015163	4,234,982	64,215	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	346,098	16,379,966	0.021129	4,898,498	103,500	73.00
76.00	03020 CARDIAC REHAB	293,873	714,486	0.411307	6,455	2,655	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	6,609	95,279	0.069365	2,460	171	90.00
90.01	09001 WOUND CENTER	63,460	359,898	0.176328	1,160	205	90.01
91.00	09100 EMERGENCY	320,169	24,067,797	0.013303	2,629,733	34,983	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	138,564	1,765,306	0.078493	71,806	5,636	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	4,582,524	159,113,834		28,906,445	709,154	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140275		Period: From 07/01/2012 To 06/30/2013		Worksheet D Part III Date/Time Prepared: 11/22/2013 8:42 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,246	0.00	6,021	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,125	0.00	641	0		31.00
43.00	04300	NURSERY	1,192	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	22,773	0.00	6,955	0		44.00
45.00	04500	NURSING FACILITY	11,643	0.00	0	0		45.00
200.00		Total (lines 30-199)	49,979		13,617	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet D
Part IV
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Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	09001	WOUND CENTER	0	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140275

Period:
From 07/01/2012
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Part IV
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	PPS
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	14,279,031	0.000000	0.000000	2,136,040	50.00
53.00	05300 ANESTHESIOLOGY	0	2,263,130	0.000000	0.000000	301,961	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	8,472,714	0.000000	0.000000	841,432	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	1,919,523	0.000000	0.000000	1,042	55.00
57.00	05700 CT SCAN	0	12,027,188	0.000000	0.000000	984,197	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	2,741,682	0.000000	0.000000	207,399	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	8,431,119	0.000000	0.000000	1,858,125	59.00
60.00	06000 LABORATORY	0	26,027,318	0.000000	0.000000	3,300,721	60.00
65.00	06500 RESPIRATORY THERAPY	0	14,427,040	0.000000	0.000000	5,178,425	65.00
66.00	06600 PHYSICAL THERAPY	0	7,522,164	0.000000	0.000000	695,447	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,028,276	0.000000	0.000000	1,556,562	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	12,591,917	0.000000	0.000000	4,234,982	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	16,379,966	0.000000	0.000000	4,898,498	73.00
76.00	03020 CARDIAC REHAB	0	714,486	0.000000	0.000000	6,455	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	95,279	0.000000	0.000000	2,460	90.00
90.01	09001 WOUND CENTER	0	359,898	0.000000	0.000000	1,160	90.01
91.00	09100 EMERGENCY	0	24,067,797	0.000000	0.000000	2,629,733	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,765,306	0.000000	0.000000	71,806	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	159,113,834			28,906,445	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XVIII Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	2,187,595	0	50.00
53.00	05300 ANESTHESIOLOGY	0	315,638	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	2,135,113	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	14,022	0	55.00
57.00	05700 CT SCAN	0	2,725,333	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	477,261	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	1,810,428	0	59.00
60.00	06000 LABORATORY	0	990,727	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	1,858,516	0	65.00
66.00	06600 PHYSICAL THERAPY	0	12,949	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	491,303	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	1,565,983	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2,653,991	0	73.00
76.00	03020 CARDIAC REHAB	0	293,914	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	23,051	0	90.00
90.01	09001 WOUND CENTER	0	179,457	0	90.01
91.00	09100 EMERGENCY	0	3,001,617	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	488,658	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (lines 50-199)	0	21,225,556	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140275	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part V Date/Time Prepared: 11/22/2013 8:42 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.335338	2,187,595	0	0	733,584	50.00
53.00	05300 ANESTHESIOLOGY	0.076747	315,638	0	0	24,224	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.289497	2,135,113	0	0	618,109	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.235053	14,022	0	0	3,296	55.00
57.00	05700 CT SCAN	0.032462	2,725,333	0	0	88,470	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.097871	477,261	0	0	46,710	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.188590	1,810,428	0	0	341,429	59.00
60.00	06000 LABORATORY	0.309450	990,727	549	275	306,580	60.00
65.00	06500 RESPIRATORY THERAPY	0.159635	1,858,516	0	0	296,684	65.00
66.00	06600 PHYSICAL THERAPY	0.436903	12,949	0	0	5,657	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.499135	491,303	126	0	245,227	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.415068	1,565,983	0	0	649,989	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.377846	2,653,991	0	38,346	1,002,800	73.00
76.00	03020 CARDIAC REHAB	1.623233	293,914	0	0	477,091	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	1.554267	23,051	0	0	35,827	90.00
90.01	09001 WOUND CENTER	0.664458	179,457	0	0	119,242	90.01
91.00	09100 EMERGENCY	0.169020	3,001,617	0	0	507,333	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.735883	488,658	0	0	359,595	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0.522904		0			95.00
200.00	Subtotal (see instructions)		21,225,556	675	38,621	5,861,847	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		21,225,556	675	38,621	5,861,847	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140275	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part V Date/Time Prepared: 11/22/2013 8:42 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	170	85		60.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	63	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	14,489		73.00
76.00 03020 CARDIAC REHAB	0	0		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 WOUND CENTER	0	0		90.01
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES	0			95.00
200.00 Subtotal (see instructions)	233	14,574		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	233	14,574		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140275 Component CCN: 145703	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part IV Date/Time Prepared: 11/22/2013 8:42 am
	Title XVIII	Skilled Nursing Facility	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
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED 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
76.00	03020 CARDIAC REHAB	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 WOUND CENTER	0	0	0	0	0	90.01
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
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: 140275 Component CCN: 145703	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part IV Date/Time Prepared: 11/22/2013 8:42 am
Title XVIII		Skilled Nursing Facility	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	14,279,031	0.000000	0.000000	0	50.00
53.00 05300 ANESTHESIOLOGY	0	2,263,130	0.000000	0.000000	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	8,472,714	0.000000	0.000000	27,624	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	1,919,523	0.000000	0.000000	0	55.00
57.00 05700 CT SCAN	0	12,027,188	0.000000	0.000000	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	2,741,682	0.000000	0.000000	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	8,431,119	0.000000	0.000000	0	59.00
60.00 06000 LABORATORY	0	26,027,318	0.000000	0.000000	102,642	60.00
65.00 06500 RESPIRATORY THERAPY	0	14,427,040	0.000000	0.000000	32,049	65.00
66.00 06600 PHYSICAL THERAPY	0	7,522,164	0.000000	0.000000	2,448,551	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,028,276	0.000000	0.000000	57,120	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	12,591,917	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	16,379,966	0.000000	0.000000	524,020	73.00
76.00 03020 CARDIAC REHAB	0	714,486	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	95,279	0.000000	0.000000	0	90.00
90.01 09001 WOUND CENTER	0	359,898	0.000000	0.000000	0	90.01
91.00 09100 EMERGENCY	0	24,067,797	0.000000	0.000000	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,765,306	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	159,113,834			3,192,006	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140275 Component CCN: 145703	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part IV Date/Time Prepared: 11/22/2013 8:42 am PPS
		Title XVIII	Skilled Nursing Facility

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00	03020 CARDIAC REHAB	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0	90.00
90.01	09001 WOUND CENTER	0	0	0	90.01
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140275	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/22/2013 8:42 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		13,246	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		13,246	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)		11,798	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)		6,021	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)		11,883,500	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)		11,883,500	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)		11,883,500	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)		897.14	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,401,680	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)		5,401,680	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140275		Period: From 07/01/2012 To 06/30/2013		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 11/22/2013 8:42 am	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	1,710,925	1,125	1,520.82	641	974,846		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)					8,435,896		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					14,812,422		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)					650,601		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					709,154		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,359,755		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					13,452,667		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					1,448		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					897.14		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,299,059		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140275		Period: From 07/01/2012 To 06/30/2013		Worksheet D-1 Date/Time Prepared: 11/22/2013 8:42 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,267,551	11,883,500	0.106665	1,299,059	138,564	90.00
91.00	Nursing School cost	0	11,883,500	0.000000	1,299,059	0	91.00
92.00	Allied health cost	0	11,883,500	0.000000	1,299,059	0	92.00
93.00	All other Medical Education	0	11,883,500	0.000000	1,299,059	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140275 Component CCN: 145703	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/22/2013 8:42 am
		Title XVIII	Skilled Nursing Facility	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)		22,773	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		22,773	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)		22,773	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)		6,955	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)		6,010,113	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)		6,010,113	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)		6,010,113	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)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140275	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1	
		Component CCN: 145703		Date/Time Prepared: 11/22/2013 8:42 am	
		Title XVIII	Skilled Nursing Facility	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				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)				48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				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)				50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				53.00
	TARGET AMOUNT AND LIMIT COMPUTATION				
54.00	Program discharges				54.00
55.00	Target amount per discharge				55.00
56.00	Target amount (line 54 x line 55)				56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				57.00
58.00	Bonus payment (see instructions)				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				59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				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)				61.00
62.00	Relief payment (see instructions)				62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				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)				64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				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)				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)				68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				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)				6,010,113 70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				263.91 71.00
72.00	Program routine service cost (line 9 x line 71)				1,835,494 72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				0 73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				1,835,494 74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				0 75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				0.00 76.00
77.00	Program capital-related costs (line 9 x line 76)				0 77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				0 78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				0 79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				0 80.00
81.00	Inpatient routine service cost per diem limitation				0.00 81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				0 82.00
83.00	Reasonable inpatient routine service costs (see instructions)				1,835,494 83.00
84.00	Program inpatient ancillary services (see instructions)				1,341,165 84.00
85.00	Utilization review - physician compensation (see instructions)				0 85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				3,176,659 86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST				
87.00	Total observation bed days (see instructions)				0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140275 Component CCN: 145703		Period: From 07/01/2012 To 06/30/2013		Worksheet D-1 Date/Time Prepared: 11/22/2013 8:42 am	
		Title XVIII		Skilled Nursing Facility		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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140275	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3 Date/Time Prepared: 11/22/2013 8:42 am	
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		7,823,029		30.00
31.00	03100 INTENSIVE CARE UNIT		2,065,156		31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.335338	2,136,040	716,295	50.00
53.00	05300 ANESTHESIOLOGY	0.076747	301,961	23,175	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.289497	841,432	243,592	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.235053	1,042	245	55.00
57.00	05700 CT SCAN	0.032462	984,197	31,949	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.097871	207,399	20,298	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.188590	1,858,125	350,424	59.00
60.00	06000 LABORATORY	0.309450	3,300,721	1,021,408	60.00
65.00	06500 RESPIRATORY THERAPY	0.159635	5,178,425	826,658	65.00
66.00	06600 PHYSICAL THERAPY	0.436903	695,447	303,843	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.499135	1,556,562	776,935	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.415068	4,234,982	1,757,806	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.377846	4,898,498	1,850,878	73.00
76.00	03020 CARDIAC REHAB	1.623233	6,455	10,478	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	1.554267	2,460	3,823	90.00
90.01	09001 WOUND CENTER	0.664458	1,160	771	90.01
91.00	09100 EMERGENCY	0.169020	2,629,733	444,477	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.735883	71,806	52,841	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		28,906,445	8,435,896	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		28,906,445		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140275 Component CCN: 145703	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3 Date/Time Prepared: 11/22/2013 8:42 am
		Title XVIII	Skilled Nursing Facility	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
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.335338	0	50.00
53.00	05300 ANESTHESIOLOGY	0.076747	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.289497	27,624	7,997 54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.235053	0	55.00
57.00	05700 CT SCAN	0.032462	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.097871	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.188590	0	59.00
60.00	06000 LABORATORY	0.309450	102,642	31,763 60.00
65.00	06500 RESPIRATORY THERAPY	0.159635	32,049	5,116 65.00
66.00	06600 PHYSICAL THERAPY	0.436903	2,448,551	1,069,779 66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.499135	57,120	28,511 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.415068	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.377846	524,020	197,999 73.00
76.00	03020 CARDIAC REHAB	1.623233	0	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	1.554267	0	90.00
90.01	09001 WOUND CENTER	0.664458	0	90.01
91.00	09100 EMERGENCY	0.169020	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.735883	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES			95.00
200.00	Total (sum of lines 50-94 and 96-98)		3,192,006	1,341,165 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net Charges (line 200 minus line 201)		3,192,006	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140275	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part A Date/Time Prepared: 11/22/2013 8:42 am	
		Title XVIII	Hospital	PPS	
		0	before 1/1	on/after 1/1	
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS					
1.00	DRG Amounts Other than Outlier Payments		12,464,935		1.00
2.00	Outlier payments for discharges. (see instructions)		31,830		2.00
2.01	Outlier reconciliation amount		0		2.01
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)		145.03		4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(F)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(F)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (F)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment. (see instructions)		0.000000		27.00
28.00	IME Adjustment (see instructions)		0		28.00
29.00	Total IME payment (sum of lines 22 and 28)		0		29.00
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.77		30.00
31.00	Percentage of Medicaid patient days (see instructions)		21.71		31.00
32.00	Sum of lines 30 and 31		24.48		32.00
33.00	Allowable disproportionate share percentage (see instructions)		9.41		33.00
34.00	Disproportionate share adjustment (see instructions)		1,172,950		34.00
Additional payment for high percentage of ESRD beneficiary discharges					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140275	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part A Date/Time Prepared: 11/22/2013 8:42 am	
		Title XVIII	Hospital	PPS	
		0	before 1/1	on/after 1/1	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0		46.00
47.00	Subtotal (see instructions)		13,669,715		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)		13,669,715		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		1,047,231		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0		55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0		56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).		0		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		14,716,946		59.00
60.00	Primary payer payments		12,122		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		14,704,824		61.00
62.00	Deductibles billed to program beneficiaries		1,506,392		62.00
63.00	Coinurance billed to program beneficiaries		21,799		63.00
64.00	Allowable bad debts (see instructions)		220,159		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		154,111		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		210,059		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		13,330,744		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	RECOVERY OF SEQUESTRATION ESTIMATE		5,280		70.00
70.92	Bundled Model 1 discount amount		0		70.92
70.93	HVBP incentive payment (see instructions)		19,209		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		-95,175		70.94
70.95	Recovery of Accelerated Depreciation		0		70.95
70.96	Low Volume Payment-1 (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low Volume Payment-2 (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)		13,260,058		71.00
71.01	Sequestration adjustment (see instructions)		66,300		71.01
72.00	Interim payments		13,612,652		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		-418,894		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0		75.00
TO BE COMPLETED BY CONTRACTOR					
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the Time Value of Money		0.00		94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140275	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part A Date/Time Prepared: 11/22/2013 8:42 am	
		Title XVIII	Hospital	PPS	
			before 1/1	on/after 1/1	
		0	1.00	1.01	
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: 140275	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part B Date/Time Prepared: 11/22/2013 8:42 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		14,807	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		5,861,847	2.00
3.00	PPS payments		5,494,469	3.00
4.00	Outlier payment (see instructions)		7,270	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		14,807	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		39,296	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)		39,296	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		39,296	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		24,489	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)		14,807	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)		5,501,739	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		56	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,225,529	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)		4,290,961	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		4,290,961	30.00
31.00	Primary payer payments		11,662	31.00
32.00	Subtotal (line 30 minus line 31)		4,279,299	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)		233,349	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		163,344	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		221,371	36.00
37.00	Subtotal (see instructions)		4,442,643	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	RECOVERY OF SEQUESTRATION ESTIMATE		-1,001	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		4,441,642	40.00
40.01	Sequestration adjustment (see instructions)		22,208	40.01
41.00	Interim payments		4,388,914	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		30,520	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: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet E-1
Part I
Date/Time Prepared:
11/22/2013 8:42 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		13,612,652		4,388,914	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		13,612,652		4,388,914	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		52,728	6.01	
6.02	SETTLEMENT TO PROGRAM		352,594		0	6.02	
7.00	Total Medicare program liability (see instructions)		13,260,058		4,441,642	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 140275 Component CCN: 145703	Period: From 07/01/2012 To 06/30/2013	Worksheet E-1 Part I Date/Time Prepared: 11/22/2013 8:42 am	
		Title XVIII	Skilled Nursing Facility	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		2,583,339		0
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
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)				
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
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)		2,583,339		0
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)				
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		12,982		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		2,596,321		0
				Contractor Number	NPR Date (Mo/Day/Yr)
			0	1.00	2.00
8.00	Name of Contractor				

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 140275		Period: From 07/01/2012 To 06/30/2013	Worksheet E-1 Part II Date/Time Prepared: 11/22/2013 8:42 am
Title XVIII		Hospital	PPS
			1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS			
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14		4,589 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12		6,662 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2		1,239 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12		12,923 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200		195,799,788 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20		6,710,962 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168		0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)		1,276,330 8.00
9.00	Sequestration adjustment amount (see instructions)		25,527 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		1,250,803 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30.00	Initial/interim HIT payment adjustment (see instructions)		0 30.00
31.00	Other Adjustment (specify)		0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		1,250,803 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140275 Component CCN: 145703	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part VI Date/Time Prepared: 11/22/2013 8:42 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		2,957,331	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		2,957,331	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		359,457	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)		2,597,874	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	RECOVERY OF SEQUESTRATION ESTIMATE		-1,553	14.00
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14)		2,596,321	15.00
15.01	Sequestration adjustment (see instructions)		12,982	15.01
16.00	Interim payments		2,583,339	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program line 15 minus 15.01, 16 and 17		0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2		0	19.00

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

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet G

Date/Time Prepared:
11/22/2013 8:42 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	17,122,250	0	0	0	1.00
2.00	Temporary investments	664,585	0	0	0	2.00
3.00	Notes receivable	841,023	0	0	0	3.00
4.00	Accounts receivable	30,276,341	0	0	0	4.00
5.00	Other receivable	51,637	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-14,584,941	0	0	0	6.00
7.00	Inventory	2,189,343	0	0	0	7.00
8.00	Prepaid expenses	534,036	0	0	0	8.00
9.00	Other current assets	2,551,488	0	0	0	9.00
10.00	Due from other funds	713,081	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	40,358,843	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,374,122	0	0	0	12.00
13.00	Land improvements	1,836,221	0	0	0	13.00
14.00	Accumulated depreciation	-1,524,965	0	0	0	14.00
15.00	Buildings	60,953,751	0	0	0	15.00
16.00	Accumulated depreciation	-32,400,293	0	0	0	16.00
17.00	Leasehold improvements	16,770	0	0	0	17.00
18.00	Accumulated depreciation	-10,029	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	43,348,686	0	0	0	23.00
24.00	Accumulated depreciation	-33,541,955	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)	41,052,308	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	4,690,696	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	5,901,581	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	10,592,277	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	92,003,428	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,844,862	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,699,383	0	0	0	38.00
39.00	Payroll taxes payable	-5,420	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,536,023	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	3,396,207	0	0	0	43.00
44.00	Other current liabilities	3,919,196	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	14,390,251	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	12,100,894	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)	12,100,894	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	26,491,145	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	65,512,283				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)	65,512,283	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	92,003,428	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet G-1

Date/Time Prepared:
11/22/2013 8:42 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		61,199,054			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		4,348,968				2.00
3.00	Total (sum of line 1 and line 2)		65,548,022			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)		65,548,022			0	11.00
12.00	Deductions (debit adjustments) (specify)	35,739		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)		35,739			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		65,512,283			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: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/22/2013 8:42 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	19,866,838		19,866,838	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	3,875,648		3,875,648	7.00
8.00	NURSING FACILITY	4,840,699		4,840,699	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	28,583,185		28,583,185	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,540,242		3,540,242	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)	3,540,242		3,540,242	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	32,123,427		32,123,427	17.00
18.00	Ancillary services	64,993,939	110,008,832	175,002,771	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	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	CROSSTOWN SQUARE	864,741	0	864,741	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	97,982,107	110,008,832	207,990,939	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		86,414,819		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		86,414,819		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140275

Period:
From 07/01/2012
To 06/30/2013

Worksheet G-3

Date/Time Prepared:
11/22/2013 8:42 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	207,990,939	1.00
2.00	Less contractual allowances and discounts on patients' accounts	111,249,371	2.00
3.00	Net patient revenues (line 1 minus line 2)	96,741,568	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	86,414,819	4.00
5.00	Net income from service to patients (line 3 minus line 4)	10,326,749	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	7,315,099	24.00
24.01	NONOPERATING GAINS & LOSSES	466,062	24.01
24.02	NUTRITIONAL REVENUE	34,063	24.02
24.03	ROUNDING	9,499	24.03
25.00	Total other income (sum of lines 6-24)	7,824,723	25.00
26.00	Total (line 5 plus line 25)	18,151,472	26.00
27.00	BAD DEBTS	6,960,622	27.00
27.01	CHARITY CARE	6,711,562	27.01
27.02	COGS	130,320	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	13,802,504	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,348,968	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140275	Period: From 07/01/2012 To 06/30/2013	Worksheet L Parts I-III Date/Time Prepared: 11/22/2013 8:42 am
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		988,339	1.00
2.00	Capital DRG outlier payments		8,586	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		36.15	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		2.77	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		21.71	8.00
9.00	Sum of lines 7 and 8		24.48	9.00
10.00	Allowable disproportionate share percentage (see instructions)		5.09	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		50,306	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		1,047,231	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