

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: 150133 Period: From 03/01/2013 To 02/28/2014 Worksheet 5 Parts I-III Date/Time Prepared: 7/30/2014 1:13 pm

PART I - COST REPORT STATUS

Provider use only 1. Electronically filed cost report Date: 7/30/2014 Time: 1:13 pm
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only 5. Cost Report Status 6. Date Received: 10. NPR Date:
 (1) As Submitted 7. Contractor No. 11. Contractor's Vendor Code: 4
 (2) Settled without Audit 8. Initial Report for this Provider CCN 12. If line 5, column 1 is 4: Enter
 (3) Settled with Audit 9. Final Report for this Provider CCN number of times reopened = 0-9.
 (4) Reopened
 (5) Amended

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 KOSCIUSKO COMMUNITY HOSPITAL (150133) for the cost reporting period beginning 03/01/2013 and ending 02/28/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title _____

Date _____

Cost Center Description	Title XVIII			HIT	Title XIX	
	Title V	Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	42,264	93,754	-57,081	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
200.00 Total	0	42,264	93,754	-57,081	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: 150133	Period: From 03/01/2013 To 02/28/2014	Worksheet S-2 Part I Date/Time Prepared: 7/30/2014 1:13 pm
---	--	----------------------	---	---

1.00	2.00	3.00	4.00
------	------	------	------

Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2101 EAST DUBOIS DRIVE	PO Box:		1.00
2.00	City: WARSAW	State: IN	Zip Code: 46580-	County: KOSCIUSKO

	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	KOSCIUSKO COMMUNITY HOSPITAL	150133	99915	1	07/01/1966	O	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

20.00	Cost Reporting Period (mm/dd/yyyy)	From: 03/01/2013	To: 02/28/2014	20.00
21.00	Type of Control (see instructions)	4		21.00

Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	Y			22.01
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						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	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.	1,901	0	0	0	405	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0		25.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet S-2
Part I
Date/Time Prepared:
7/30/2014 1:13 pm

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N		39.00

		V	XVIII	XIX
		1.00	2.00	3.00

Prospective Payment System (PPS)-Capital					
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00

Teaching Hospitals					
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150133	Period: From 03/01/2013 To 02/28/2014	Worksheet S-2 Part I Date/Time Prepared: 7/30/2014 1:13 pm		
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20
		1.00				
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))
				1.00	2.00	3.00
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000 64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))
				1.00	2.00	3.00
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000 66.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet S-2
Part I
Date/Time Prepared:
7/30/2014 1:13 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet S-2
Part I
Date/Time Prepared:
7/30/2014 1:13 pm

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

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	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.	Y			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	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	100,671	63,418		0118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02

119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00

Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00

All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		449008	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150133	Period: From 03/01/2013 To 02/28/2014	Worksheet S-2 Part I Date/Time Prepared: 7/30/2014 1:13 pm
---	--	----------------------	---	---

1.00		2.00		3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141.00	Name: CHS/COMMUNITY HEALTH SYSTEMS, INC.	Contractor's Name: WPS		Contractor's Number: 522280		141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:				142.00
143.00	City: FRANKLIN	State: TN		Zip Code: 37067		143.00

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

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

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

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

	Name 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 5.00	

		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)		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 1.00	Ending 2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	03/01/2013	02/28/2014	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet 5-2
Part II
Date/Time Prepared:
7/30/2014 1:13 pm

	Description	Part A		Part B	
		Y/N	Date	Y/N	
	0	1.00	2.00	3.00	
21.00	was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	were home office costs claimed on the cost report?	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.	Y	12/31/2013		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N			40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JEREMY		BURLESON	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(615) 465-3427		JEREMY_BURLESON@CHS.NET	43.00

		Part B		
		Date		
		4.00		
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	07/15/2014		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR, REVENUE MANAGEMENT		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: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet S-3
Part I
Date/Time Prepared:
7/30/2014 1:13 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				1.00	2.00
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	58	21,170	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)		58	21,170	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	14	5,110	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)		72	26,280	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			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)		72				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,904	1,191	10,535			1.00
2.00 HMO and other (see instructions)	2,591	405				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)	3,904	1,191	10,535			7.00
8.00 INTENSIVE CARE UNIT	343	125	987			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		585	1,194			13.00
14.00 Total (see instructions)	4,247	1,901	12,716	0.00	478.07	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	0.00	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	478.07	27.00
28.00 Observation Bed Days		0	2,375			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

Component	Discharges					Total All Patients	
	Full Time Equivalents	Title V	Title XVIII	Title XIX			
	Nonpaid Workers	12 00	13 00	14 00	15 00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,071	489	3,509	1.00	
2.00 HMO and other (see instructions)			634			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	1,071	489	3,509	14.00	
15.00 CAH visits						15.00	
16.00 SUBPROVIDER - IPF						16.00	
17.00 SUBPROVIDER - IRF						17.00	
18.00 SUBPROVIDER						18.00	
19.00 SKILLED NURSING FACILITY						19.00	
20.00 NURSING FACILITY						20.00	
21.00 OTHER LONG TERM CARE						21.00	
22.00 HOME HEALTH AGENCY						22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00	
24.00 HOSPICE	0.00					24.00	
24.10 HOSPICE (non-distinct part)						24.10	
25.00 CMHC - CMHC						25.00	
26.00 RURAL HEALTH CLINIC						26.00	
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25	
27.00 Total (sum of lines 14-26)	0.00					27.00	
28.00 Observation Bed Days						28.00	
29.00 Ambulance Trips						29.00	
30.00 Employee discount days (see instruction)						30.00	
31.00 Employee discount days - IRF						31.00	
32.00 Labor & delivery days (see instructions)						32.00	
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01	
33.00 LTCH non-covered days						33.00	

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	22,724,495	0	22,724,495	994,387.00	22.85
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		13,371	0	13,371	98.50	135.75
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		31,184	130,798	161,982	7,686.00	21.07
OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		1,344,245	0	1,344,245	24,727.00	54.36
12.00	Contract management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		108,170	0	108,170	715.29	151.23
14.00	Home office salaries & wage-related costs		1,803,393	0	1,803,393	28,656.00	62.93
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)		5,475,766	0	5,475,766		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		42,498	0	42,498		
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		1,210	0	1,210		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	154,925	0	154,925	5,989.00	25.87
27.00	Administrative & General	5.00	4,257,956	-283,974	3,973,982	181,490.00	21.90
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	490,743	0	490,743	25,264.00	19.42
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00
32.00	Housekeeping	9.00	591,262	0	591,262	47,701.00	12.40
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	644,780	-480,220	164,560	12,566.99	13.09
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	480,220	480,220	36,673.01	13.09
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	704,946	153,176	858,122	23,645.00	36.29
39.00	Central Services and Supply	14.00	241,994	0	241,994	15,523.00	15.59
40.00	Pharmacy	15.00	813,414	0	813,414	21,674.00	37.53
41.00	Medical Records & Medical Records Library	16.00	449,581	0	449,581	27,688.00	16.24

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet S-3
Part II
Date/Time Prepared:
7/30/2014 1:13 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
42.00	Social Service	17.00	0	0	0	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet S-3
Part III
Date/Time Prepared:
7/30/2014 1:13 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	22,724,495	0	22,724,495	994,387.00	22.85	1.00
2.00	Excluded area salaries (see instructions)	31,184	130,798	161,982	7,686.00	21.07	2.00
3.00	Subtotal salaries (line 1 minus line 2)	22,693,311	-130,798	22,562,513	986,701.00	22.87	3.00
4.00	Subtotal other wages & related costs (see inst.)	3,255,808	0	3,255,808	54,098.29	60.18	4.00
5.00	Subtotal wage-related costs (see inst.)	5,476,976	0	5,476,976	0.00	24.27	5.00
6.00	Total (sum of lines 3 thru 5)	31,426,095	-130,798	31,295,297	1,040,799.29	30.07	6.00
7.00	Total overhead cost (see instructions)	8,349,601	-130,798	8,218,803	398,214.00	20.64	7.00

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401k Employer Contributions	554,455	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)	2,854,976	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	47,914	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	26,653	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	367	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	26,132	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'workers' Compensation Insurance	180,136	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	1,276,962	17.00
18.00	Medicare Taxes - Employers Portion Only	298,644	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	181,275	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,447,514	24.00
Part B - Other than Core Related Cost			
25.00	RELOCATION, ID THEFT & OTHER BENEFIT	72,692	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet S-3
Part V
Date/Time Prepared:
7/30/2014 1:13 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,344,245	5,475,766	1.00
2.00	Hospital	1,344,245	5,475,766	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	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

		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)	0.136484		1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	5,487,418		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0		5.00
6.00	Medicaid charges	52,844,057		6.00
7.00	Medicaid cost (line 1 times line 6)	7,212,368		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)	1,724,950		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)	529,893		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	4,812,174		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	656,785		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)	126,892		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)	1,851,842		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	809,705	351,879	1,161,584
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	110,512	48,026	158,538
22.00	Partial payment by patients approved for charity care	3,997	18,538	22,535
23.00	Cost of charity care (line 21 minus line 22)	106,515	29,488	136,003
		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)	17,351,780		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	225,744		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	17,126,036		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	2,337,430		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,473,433		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,325,275		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet A

Date/Time Prepared:
7/30/2014 1:13 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (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		1,720,099	1,720,099	955,653	2,675,752	1.00
2.00	00200		3,686,246	3,686,246	521,462	4,207,708	2.00
4.00	00400	154,925	116,789	271,714	3,725,472	3,997,186	4.00
5.01	00510	4,257,956	35,728,092	39,986,048	-28,897,663	11,088,385	5.01
5.02	00560	0	0	0	24,169,644	24,169,644	5.02
7.00	00700	490,743	1,559,002	2,049,745	85,381	2,135,126	7.00
8.00	00800	0	326,717	326,717	0	326,717	8.00
9.00	00900	591,262	223,083	814,345	0	814,345	9.00
10.00	01000	644,780	680,829	1,325,609	-987,391	338,218	10.00
11.00	01100	0	0	0	986,988	986,988	11.00
13.00	01300	704,946	182,027	886,973	152,738	1,039,711	13.00
14.00	01400	241,994	3,142,335	3,384,329	-2,799,085	585,244	14.00
15.00	01500	813,414	6,346,707	7,160,121	-6,034,990	1,125,131	15.00
16.00	01600	449,581	442,682	892,263	-579	891,684	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	3,745,139	1,796,527	5,541,666	-697,790	4,843,876	30.00
31.00	03100	1,187,210	219,954	1,407,164	-3,475	1,403,689	31.00
43.00	04300	0	0	0	206,989	206,989	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,326,068	1,057,947	2,384,015	-22,645	2,361,370	50.00
51.00	05100	623,191	126,305	749,496	-168	749,328	51.00
52.00	05200	0	0	0	484,389	484,389	52.00
53.00	05300	0	1,127,440	1,127,440	-21,966	1,105,474	53.00
54.00	05400	1,917,097	1,708,332	3,625,429	-1,393,037	2,232,392	54.00
54.01	05401	422,287	102,316	524,603	-524,603	0	54.01
54.02	05402	-96	39	-57	1,608,035	1,607,978	54.02
56.00	05600	130,658	192,493	323,151	0	323,151	56.00
57.00	05700	238,650	355,647	594,297	-46,664	547,633	57.00
58.00	05800	260,036	589,518	849,554	-252,407	597,147	58.00
60.00	06000	1,185,478	2,028,709	3,214,187	-143,891	3,070,296	60.00
65.00	06500	396,231	66,327	462,558	161,298	623,856	65.00
66.00	06600	601,860	1,327,598	1,929,458	-720	1,928,738	66.00
67.00	06700	23,165	197,948	221,113	-197	220,916	67.00
68.00	06800	0	21,649	21,649	0	21,649	68.00
69.00	06900	79,077	9,932	89,009	0	89,009	69.00
71.00	07100	0	0	0	496,215	496,215	71.00
72.00	07200	0	0	0	2,304,033	2,304,033	72.00
73.00	07300	0	0	0	5,871,466	5,871,466	73.00
76.00	03020	0	0	0	0	0	76.00
76.01	03021	120,581	40,876	161,457	-161,457	0	76.01
76.02	03022	0	0	0	0	0	76.02
76.03	03023	51,835	24,257	76,092	-76,092	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	589,100	64,426	653,526	73,048	726,574	90.00
91.00	09100	1,446,143	497,641	1,943,784	-763	1,943,021	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
96.00	09600	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	0	0	0	116.00
118.00		22,693,311	65,710,489	88,403,800	-262,772	88,141,028	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	31,184	29,100	60,284	-118	60,166	190.00
192.00	19200	0	-39,661	-39,661	-150,641	-190,302	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	412,790	412,790	194.01
194.02	07952	0	-741	-741	741	0	194.02
194.03	07953	0	0	0	0	0	194.03
200.00		22,724,495	65,699,187	88,423,682	0	88,423,682	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CGN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet A
Date/Time Prepared:
7/30/2014 1:13 pm

Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	3,069,585	5,745,337	1.00
2.00	00200	-943,028	3,264,680	2.00
4.00	00400	-2,012	3,995,174	4.00
5.01	00510	91,396	11,179,781	5.01
5.02	00560	-21,193,976	2,975,668	5.02
7.00	00700	-20,750	2,114,376	7.00
8.00	00800	-19,120	307,597	8.00
9.00	00900	0	814,345	9.00
10.00	01000	0	338,218	10.00
11.00	01100	-394,209	592,779	11.00
13.00	01300	0	1,039,711	13.00
14.00	01400	0	585,244	14.00
15.00	01500	0	1,125,131	15.00
16.00	01600	-755	890,929	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	-1,117,504	3,726,372	30.00
31.00	03100	0	1,403,689	31.00
43.00	04300	0	206,989	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	0	2,361,370	50.00
51.00	05100	0	749,328	51.00
52.00	05200	0	484,389	52.00
53.00	05300	-1,105,474	0	53.00
54.00	05400	-1,538	2,230,854	54.00
54.01	05401	0	0	54.01
54.02	05402	-269,360	1,338,618	54.02
56.00	05600	-270	322,881	56.00
57.00	05700	-8,894	538,739	57.00
58.00	05800	-27,618	569,529	58.00
60.00	06000	-34,963	3,035,333	60.00
65.00	06500	0	623,856	65.00
66.00	06600	0	1,928,738	66.00
67.00	06700	0	220,916	67.00
68.00	06800	0	21,649	68.00
69.00	06900	0	89,009	69.00
71.00	07100	0	496,215	71.00
72.00	07200	0	2,304,033	72.00
73.00	07300	0	5,871,466	73.00
76.00	03020	0	0	76.00
76.01	03021	0	0	76.01
76.02	03022	0	0	76.02
76.03	03023	0	0	76.03
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	0	726,574	90.00
91.00	09100	-30,479	1,912,542	91.00
92.00	09200	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	0	0	95.00
96.00	09600	0	0	96.00
SPECIAL PURPOSE COST CENTERS				
116.00	11600	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)		66,132,059	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	0	60,166	190.00
192.00	19200	344,557	154,255	192.00
192.01	19201	0	0	192.01
194.00	07950	0	0	194.00
194.01	07951	0	412,790	194.01
194.02	07952	0	0	194.02
194.03	07953	0	0	194.03
200.00	TOTAL (SUM OF LINES 118-199)		66,759,270	200.00

	Cost Center 2.00	Increases			
		Line # 3.00	Salary 4.00	Other 5.00	
A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,725,835	1.00
	TOTALS		0	3,725,835	
B - OXYGEN					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	52,128	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	52,128	
C - LEASE AND RENTAL					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	459,525	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	506,825	2.00
3.00	ADMINISTRATIVE & GENERAL	5.01	0	12,215	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
	TOTALS		0	978,565	
D - OTHER CAPITAL					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	104,451	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	391,677	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	14,637	3.00
	TOTALS		0	510,765	
E - MARKETING					
1.00	MARKETING	194.01	130,798	282,733	1.00
	TOTALS		130,798	282,733	
F - CNO COST					
1.00	NURSING ADMINISTRATION	13.00	153,176	0	1.00
	TOTALS		153,176	0	
G - CHARGABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	444,087	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,304,033	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	2,748,120	
H - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,871,466	1.00
	TOTALS		0	5,871,466	
I - LABOR AND DELIVERY					
1.00	NURSERY	43.00	172,673	34,316	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	404,084	80,305	2.00
	TOTALS		576,757	114,621	
J - MISC DEPARTMENTS					
1.00	CLINIC	90.00	51,835	24,257	1.00
2.00	RESPIRATORY THERAPY	65.00	120,581	40,717	2.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	2,092,240	22,077,404	3.00
4.00	SENIOR CIRCLE	194.02	0	741	4.00
	TOTALS		2,264,656	22,143,119	
K - RADIOLOGY					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	422,287	102,316	1.00
2.00	ONCOLOGY	54.02	774,878	833,157	2.00
	TOTALS		1,197,165	935,473	
L - DIETARY					
1.00	CAFETERIA	11.00	480,220	506,768	1.00
	TOTALS		480,220	506,768	

Health Financial Systems
RECLASSIFICATIONS

KOSCIUSKO COMMUNITY HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet A-6
Date/Time Prepared:
7/30/2014 1:13 pm

		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
M - MOB UTILITIES						
1.00	OPERATION OF PLANT		7.00	0	87,568	1.00
	TOTALS			0	87,568	
500.00	Grand Total: Increases			4,802,772	37,957,161	500.00

		Decreases			Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other			
6.00	7.00	8.00	9.00	10.00		
A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.01	0	3,725,835	0	1.00
	TOTALS		0	3,725,835		
B - OXYGEN						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	29,892	0	1.00
2.00	ANESTHESIOLOGY	53.00	0	21,966	0	2.00
3.00	LABORATORY	60.00	0	270	0	3.00
	TOTALS		0	52,128		
C - LEASE AND RENTAL						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	363	10	1.00
2.00	OPERATION OF PLANT	7.00	0	2,187	10	2.00
3.00	DIETARY	10.00	0	403	0	3.00
4.00	NURSING ADMINISTRATION	13.00	0	438	0	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	44,797	0	5.00
6.00	PHARMACY	15.00	0	163,524	0	6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	579	0	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	6,412	0	8.00
9.00	INTENSIVE CARE UNIT	31.00	0	3,475	0	9.00
10.00	OPERATING ROOM	50.00	0	927	0	10.00
11.00	RECOVERY ROOM	51.00	0	168	0	11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	309,605	0	12.00
13.00	CT SCAN	57.00	0	46,664	0	13.00
14.00	MRI	58.00	0	252,407	0	14.00
15.00	LABORATORY	60.00	0	143,621	0	15.00
16.00	PHYSICAL THERAPY	66.00	0	720	0	16.00
17.00	OCCUPATIONAL THERAPY	67.00	0	197	0	17.00
18.00	SLEEP LAB	76.01	0	159	0	18.00
19.00	CLINIC	90.00	0	1,038	0	19.00
20.00	EMERGENCY	91.00	0	763	0	20.00
21.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	118	0	21.00
	TOTALS		0	978,565		
D - OTHER CAPITAL						
1.00	ADMINISTRATIVE & GENERAL	5.01	0	447,692	12	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	63,073	13	2.00
3.00		0.00	0	0	12	3.00
	TOTALS		0	510,765		
E - MARKETING						
1.00	ADMINISTRATIVE & GENERAL	5.01	130,798	282,733	0	1.00
	TOTALS		130,798	282,733		
F - CNO COST						
1.00	ADMINISTRATIVE & GENERAL	5.01	153,176	0	0	1.00
	TOTALS		153,176	0		
G - CHARGABLE SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,724,396	0	1.00
2.00	OPERATING ROOM	50.00	0	21,718	0	2.00
3.00	CLINIC	90.00	0	2,006	0	3.00
	TOTALS		0	2,748,120		
H - DRUGS						
1.00	PHARMACY	15.00	0	5,871,466	0	1.00
	TOTALS		0	5,871,466		
I - LABOR AND DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	576,757	114,621	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		576,757	114,621		
J - MISC DEPARTMENTS						
1.00	WOUND CARE	76.03	51,835	24,257	0	1.00
2.00	SLEEP LAB	76.01	120,581	40,717	0	2.00
3.00	ADMINISTRATIVE & GENERAL	5.01	2,092,240	22,077,404	0	3.00
4.00	MARKETING	194.01	0	741	0	4.00
	TOTALS		2,264,656	22,143,119		
K - RADIOLOGY						
1.00	ULTRASOUND	54.01	422,287	102,316	0	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	774,878	833,157	0	2.00
	TOTALS		1,197,165	935,473		
L - DIETARY						
1.00	DIETARY	10.00	480,220	506,768	0	1.00
	TOTALS		480,220	506,768		
M - MOB UTILITIES						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	87,568	0	1.00
	TOTALS		0	87,568		
500.00	Grand Total: Decreases		4,802,772	37,957,161		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet A-7
Part I
Date/Time Prepared:
7/30/2014 1:13 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,381,252	0	0	0	1.00
2.00	Land Improvements	1,843,608	37,680	0	37,680	2.00
3.00	Buildings and Fixtures	55,236,205	96,960	0	96,960	3.00
4.00	Building Improvements	44,845	0	0	0	4.00
5.00	Fixed Equipment	4,893,189	133,719	0	133,719	5.00
6.00	Movable Equipment	35,426,323	2,814,810	0	2,814,810	6.00
7.00	HIT designated Assets	2,208,180	166,917	0	166,917	7.00
8.00	Subtotal (sum of lines 1-7)	102,033,602	3,250,086	0	3,250,086	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	102,033,602	3,250,086	0	3,250,086	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,381,252	0			1.00
2.00	Land Improvements	1,881,288	0			2.00
3.00	Buildings and Fixtures	55,331,066	0			3.00
4.00	Building Improvements	44,845	0			4.00
5.00	Fixed Equipment	4,938,918	0			5.00
6.00	Movable Equipment	38,055,649	0			6.00
7.00	HIT designated Assets	2,375,097	0			7.00
8.00	Subtotal (sum of lines 1-7)	105,008,115	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	105,008,115	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CGN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet A-7
Part II
Date/Time Prepared:
7/30/2014 1:13 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	1,720,099	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,686,246	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,406,345	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	1,720,099		1.00		
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,686,246		2.00		
3.00	Total (sum of lines 1-2)	0	5,406,345		3.00		

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet A-7
Part III
Date/Time Prepared:
7/30/2014 1:13 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	59,638,452	0	59,638,452	0.567941	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	45,369,663	0	45,369,663	0.432059	0	2.00
3.00	Total (sum of lines 1-2)	105,008,115	0	105,008,115	1.000000	0	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,422,644	361,081	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,510,526	506,825	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,933,170	867,906	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	2,465,484	104,451	391,677	0	5,745,337	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	232,692	14,637	0	0	3,264,680	2.00
3.00	Total (sum of lines 1-2)	2,698,176	119,088	391,677	0	9,010,017	3.00

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7	Ref.
				3.00	4.00			
				5.00				
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00		0 1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00		0 2.00
3.00	Investment income - other (chapter 2)			0		0.00		0 3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0		0.00		0 4.00
5.00	Refunds and rebates of expenses (chapter 8)			0		0.00		0 5.00
6.00	Rental of provider space by suppliers (chapter 8)			0		0.00		0 6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	B	-816		ADMINISTRATIVE & GENERAL	5.01		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	-2,644,898					0 10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-455		RADIOLOGY-DIAGNOSTIC	54.00		0 11.00
12.00	Related organization transactions (chapter 10)	A-8-1	2,361,271					0 12.00
13.00	Laundry and linen service			0		0.00		0 13.00
14.00	Cafeteria-employees and guests	B	-394,209		CAFETERIA	11.00		0 14.00
15.00	Rental of quarters to employee and others			0		0.00		0 15.00
16.00	Sale of medical and surgical supplies to other than patients			0		0.00		0 16.00
17.00	Sale of drugs to other than patients			0		0.00		0 17.00
18.00	Sale of medical records and abstracts	B	-755		MEDICAL RECORDS & LIBRARY	16.00		0 18.00
19.00	Nursing school (tuition, fees, books, etc.)			0		0.00		0 19.00
20.00	Vending machines			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	0		RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0		PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	702,545		CAP REL COSTS-BLDG & FIXT	1.00		9 26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-1,164,515		CAP REL COSTS-MVBLE EQUIP	2.00		9 27.00
28.00	Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0		0.00		0 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0		OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0		SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0		0.00		0 32.00
33.00	PENALTIES	A	-16,050		ADMINISTRATIVE & GENERAL	5.01		0 33.00
34.00	RENTAL INCOME	B	-98,444		CAP REL COSTS-BLDG & FIXT	1.00		10 34.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center	Line #	Wkst. A-7 Ref.
	1.00	2.00	3.00	4.00	5.00
35.00 MISC INCOME	B	-61,095	ADMINISTRATIVE & GENERAL	5.01	0 35.00
36.00 HOSPITAL BAD DEBT	A	-19,820,961	OTHER ADMINISTRATIVE AND GENERAL	5.02	0 36.00
37.00 PATIENT PHONE WAGE COST	A	-8,285	OTHER ADMINISTRATIVE AND GENERAL	5.02	0 37.00
38.00 PATIENT PHONE BENEFIT COSTS	A	-2,012	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 38.00
39.00 PATIENT PHONE EXPENSE	A	-8,757	OTHER ADMINISTRATIVE AND GENERAL	5.02	0 39.00
40.00 PATIENT PHONE DEPRECIATION	A	-734	CAP REL COSTS-MVBLE EQUIP	2.00	9 40.00
41.00 PATIENT TV - CABLE EXPENSE	A	-20,750	OPERATION OF PLANT	7.00	0 41.00
42.00 PATIENT TV - DEPRECIATION	A	-10,471	CAP REL COSTS-MVBLE EQUIP	2.00	9 42.00
43.00 MARKETING	A	-147,037	ADMINISTRATIVE & GENERAL	5.01	0 43.00
44.00 PHYSICIAN RECRUITING	A	-170,765	ADMINISTRATIVE & GENERAL	5.01	0 44.00
45.00 CHARITABLE CONTRIBUTIONS	A	-14,636	ADMINISTRATIVE & GENERAL	5.01	0 45.00
45.01 UNCOLLECTED PHYSICAN RENT	A	-3,011	OTHER ADMINISTRATIVE AND GENERAL	5.02	0 45.01
45.02 CLUB DUES	A	-4,200	ADMINISTRATIVE & GENERAL	5.01	0 45.02
45.03 MINORITY INTEREST	A	-454,740	OTHER ADMINISTRATIVE AND GENERAL	5.02	0 45.03
45.04 LOBBYING EXPENSE IN ASSOCIATION DUES	A	-2,553	ADMINISTRATIVE & GENERAL	5.01	0 45.04
45.05 TRANSPORTATION COSTS	A	-275	ADMINISTRATIVE & GENERAL	5.01	0 45.05
45.06 LEGAL FEES	A	-21,763	ADMINISTRATIVE & GENERAL	5.01	0 45.06
45.07 POB DEPRECIATION	A	-222,350	PHYSICIANS' PRIVATE OFFICES	192.00	0 45.07
45.08 POB RENT	B	566,907	PHYSICIANS' PRIVATE OFFICES	192.00	0 45.08
45.09 ALCOHOL BEVERAGES	A	-598	ADMINISTRATIVE & GENERAL	5.01	0 45.09
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-21,664,412			50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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

Provider CCN: 150133

Period: From 03/01/2013 To 02/28/2014

Worksheet A-8-1

Date/Time Prepared: 7/30/2014 1:13 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	DIRECT ALLOCATATION - INTERE	2,377,781	0
2.00	5.01	ADMINISTRATIVE & GENERAL	PASI OPERTAING COSTS	441,131	0
3.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BUILDIN	24,436	0
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - EQUIPME	12,224	0
4.01	1.00	CAP REL COSTS-BLDG & FIXT	ALLOCATED - BUILDING	27,521	0
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	ALLOCATED - EQUIPMENT	220,468	0
4.03	5.01	ADMINISTRATIVE & GENERAL	ALLOCATED HOME OFFICE COSTS	1,675,499	0
4.04	5.01	ADMINISTRATIVE & GENERAL	MALPRACTICE - HOSPITAL	164,089	550,097
4.05	5.02	OTHER ADMINISTRATIVE AND GEN	MANAGEMENT FEES	0	132,330
4.06	5.01	ADMINISTRATIVE & GENERAL	401K FEES	0	3,762
4.07	5.01	ADMINISTRATIVE & GENERAL	AUDIT FEES	0	73,261
4.08	5.01	ADMINISTRATIVE & GENERAL	MIS FEES	0	559,505
4.09	5.01	ADMINISTRATIVE & GENERAL	MANAGED CARE	0	64,175
4.10	5.01	ADMINISTRATIVE & GENERAL	CASE MANAGEMENT	0	203,635
4.11	5.01	ADMINISTRATIVE & GENERAL	PURCHASE & ANCILLARY	0	14,331
4.12	5.01	ADMINISTRATIVE & GENERAL	EMERGENCY ROOM	0	113,181
4.13	5.01	ADMINISTRATIVE & GENERAL	PBS ENROLLMENT FEES	0	24,878
4.14	5.01	ADMINISTRATIVE & GENERAL	COMPLIANCE FEES	0	60,498
4.15	5.01	ADMINISTRATIVE & GENERAL	SENIOR CIRCLE	0	32,959
4.16	5.02	OTHER ADMINISTRATIVE AND GEN	PASI COLLECTION FEES	0	589,395
4.18	5.02	OTHER ADMINISTRATIVE AND GEN	PASI EBOS	0	3,771
4.19	5.02	OTHER ADMINISTRATIVE AND GEN	PASI LIEN UNIT	0	161,792
4.20	8.00	LAUNDRY & LINEN SERVICE	HOSPITAL LAUNDRY SERVICE - O	307,538	326,658
4.21	1.00	CAP REL COSTS-BLDG & FIXT	HOSPITAL LAUNDRY SERVICE - C	35,746	0
4.22	5.02	OTHER ADMINISTRATIVE AND GEN	CIG ASSETS	45,096	56,030
5.00	TOTALS (sum of lines 1-4).			5,331,529	2,970,258
Transfer column 6, line 5 to worksheet A-8, column 2, line 12.					

* 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	B		0.00	COMMUNITY HEALTH SYSTEMS	100.00	6.00
7.00	C		0.00	HOSPITAL LAUNDR	20.00	7.00
8.00	G		0.00	PASI	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.

	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	2,377,781	11	1.00
2.00	441,131	0	2.00
3.00	24,436	11	3.00
4.00	12,224	11	4.00
4.01	27,521	11	4.01
4.02	220,468	11	4.02
4.03	1,675,499	0	4.03
4.04	-386,008	0	4.04
4.05	-132,330	0	4.05
4.06	-3,762	0	4.06
4.07	-73,261	0	4.07
4.08	-559,505	0	4.08
4.09	-64,175	0	4.09
4.10	-203,635	0	4.10
4.11	-14,331	0	4.11
4.12	-113,181	0	4.12
4.13	-24,878	0	4.13
4.14	-60,498	0	4.14
4.15	-32,959	0	4.15
4.16	-589,395	0	4.16
4.18	-3,771	0	4.18
4.19	-161,792	0	4.19
4.20	-19,120	0	4.20
4.21	35,746	11	4.21
4.22	-10,934	0	4.22
5.00	2,361,271		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	HOSPITAL MANAGEMENT	6.00
7.00	LAUNDRY SERVICES	7.00
8.00	DEBT COLLECTION	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.

Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours
1.00	2.00	3.00	4.00	5.00	6.00	7.00
1.00	5.01 ADMINISTRATIVE & GENERAL	61,392	35,118	26,274	159,800	158
2.00	30.00 ADULTS & PEDIATRICS	1,117,504	1,117,504	0	0	0
3.00	53.00 ANESTHESIOLOGY	1,105,474	1,105,474	0	0	0
4.00	54.00 RADIOLOGY-DIAGNOSTIC	1,083	1,083	0	0	0
5.00	54.02 ONCOLOGY	269,360	269,360	0	0	0
6.00	56.00 RADIOISOTOPE	270	270	0	0	0
7.00	57.00 CT SCAN	8,894	8,894	0	0	0
8.00	58.00 MRI	27,618	27,618	0	0	0
9.00	60.00 LABORATORY	34,963	34,963	0	0	0
10.00	91.00 EMERGENCY	30,479	30,479	0	0	0
200.00		2,657,037	2,630,763	26,274		158

Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance
1.00	2.00	8.00	9.00	12.00	13.00	14.00
1.00	5.01 ADMINISTRATIVE & GENERAL	12,139	607	0	0	0
2.00	30.00 ADULTS & PEDIATRICS	0	0	0	0	0
3.00	53.00 ANESTHESIOLOGY	0	0	0	0	0
4.00	54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
5.00	54.02 ONCOLOGY	0	0	0	0	0
6.00	56.00 RADIOISOTOPE	0	0	0	0	0
7.00	57.00 CT SCAN	0	0	0	0	0
8.00	58.00 MRI	0	0	0	0	0
9.00	60.00 LABORATORY	0	0	0	0	0
10.00	91.00 EMERGENCY	0	0	0	0	0
200.00		12,139	607	0	0	0

Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment
1.00	2.00	15.00	16.00	17.00	18.00
1.00	5.01 ADMINISTRATIVE & GENERAL	0	12,139	14,135	49,253
2.00	30.00 ADULTS & PEDIATRICS	0	0	0	1,117,504
3.00	53.00 ANESTHESIOLOGY	0	0	0	1,105,474
4.00	54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	1,083
5.00	54.02 ONCOLOGY	0	0	0	269,360
6.00	56.00 RADIOISOTOPE	0	0	0	270
7.00	57.00 CT SCAN	0	0	0	8,894
8.00	58.00 MRI	0	0	0	27,618
9.00	60.00 LABORATORY	0	0	0	34,963
10.00	91.00 EMERGENCY	0	0	0	30,479
200.00		0	12,139	14,135	2,644,898

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	5,745,337	5,745,337			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	3,264,680		3,264,680		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	3,995,174	15,312	8,701	4,019,187	4.00
5.01 00510	ADMINISTRATIVE & GENERAL	11,179,781	286,163	162,607	335,101	11,963,652
5.02 00560	OTHER ADMINISTRATIVE AND GENERAL	2,975,668	459,647	261,186	372,586	4,069,087
7.00 00700	OPERATION OF PLANT	2,114,376	473,107	268,834	87,392	2,943,709
8.00 00800	LAUNDRY & LINEN SERVICE	307,597	9,501	5,399	0	322,497
9.00 00900	HOUSEKEEPING	814,345	18,938	10,761	105,292	949,336
10.00 01000	DIETARY	338,218	55,073	31,294	29,305	453,890
11.00 01100	CAFETERIA	592,779	46,269	26,291	85,518	750,857
13.00 01300	NURSING ADMINISTRATION	1,039,711	11,987	6,811	152,814	1,211,323
14.00 01400	CENTRAL SERVICES & SUPPLY	585,244	31,828	18,085	43,094	678,251
15.00 01500	PHARMACY	1,125,131	39,745	22,584	144,853	1,332,313
16.00 01600	MEDICAL RECORDS & LIBRARY	890,929	43,862	24,924	80,061	1,039,776
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	3,726,372	665,972	378,426	564,223	5,334,993
31.00 03100	INTENSIVE CARE UNIT	1,403,689	148,861	84,588	211,418	1,848,556
43.00 04300	NURSERY	206,989	14,251	8,098	30,750	260,088
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	2,361,370	277,185	157,505	236,146	3,032,206
51.00 05100	RECOVERY ROOM	749,328	13,064	7,423	110,978	880,793
52.00 05200	DELIVERY ROOM & LABOR ROOM	484,389	54,503	30,970	71,959	641,821
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,230,854	206,452	117,312	278,607	2,833,225
54.01 05401	ULTRASOUND	0	0	0	0	0
54.02 05402	ONCOLOGY	1,338,618	186,880	106,191	137,973	1,769,662
56.00 05600	RADIOISOTOPE	322,881	8,091	4,598	23,268	358,838
57.00 05700	CT SCAN	538,739	30,672	17,429	42,499	629,339
58.00 05800	MRI	569,529	53,078	30,160	46,307	699,074
60.00 06000	LABORATORY	3,035,333	94,913	53,932	211,110	3,395,288
65.00 06500	RESPIRATORY THERAPY	623,856	47,868	27,200	92,034	790,958
66.00 06600	PHYSICAL THERAPY	1,928,738	139,851	79,468	107,179	2,255,236
67.00 06700	OCCUPATIONAL THERAPY	220,916	0	0	4,125	225,041
68.00 06800	SPEECH PATHOLOGY	21,649	1,583	900	0	24,132
69.00 06900	ELECTROCARDIOLOGY	89,009	792	450	14,082	104,333
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	496,215	0	0	0	496,215
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	2,304,033	0	0	0	2,304,033
73.00 07300	DRUGS CHARGED TO PATIENTS	5,871,466	0	0	0	5,871,466
76.00 03020	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0
76.01 03021	SLEEP LAB	0	0	0	0	0
76.02 03022	PSYCH ANCILLARY SERVICES	0	0	0	0	0
76.03 03023	WOUND CARE	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	726,574	60,298	34,263	114,138	935,273
91.00 09100	EMERGENCY	1,912,542	212,184	120,569	257,529	2,502,824
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
116.00 11600	HOSPICE	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	66,132,059	3,707,930	2,106,959	3,990,341	62,908,085
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	60,166	9,738	5,534	5,553	80,991
192.00 19200	PHYSICIANS' PRIVATE OFFICES	154,255	1,807,821	1,027,263	0	2,989,339
192.01 19201	WELLNESS CENTER	0	186,738	106,110	0	292,848
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01 07951	MARKETING	412,790	33,110	18,814	23,293	488,007
194.02 07952	SENIOR CIRCLE	0	0	0	0	0
194.03 07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
200.00	Cross Foot Adjustments	0	0	0	0	0
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118-201)	66,759,270	5,745,337	3,264,680	4,019,187	66,759,270

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet B
Part I
Date/Time Prepared:
7/30/2014 1:13 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5.01	5A.01	5.02	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510	11,963,652					5.01
5.02	00560	888,412	4,957,499	4,957,499			5.02
7.00	00700	642,706	3,586,415	305,702	3,892,117		7.00
8.00	00800	70,411	392,908	33,491	8,197	434,596	8.00
9.00	00900	207,270	1,156,606	98,588	16,340	0	9.00
10.00	01000	99,099	552,989	47,136	47,516	0	10.00
11.00	01100	163,936	914,793	77,976	39,920	0	11.00
13.00	01300	264,471	1,475,794	125,795	10,342	0	13.00
14.00	01400	148,084	826,335	70,436	27,460	15,077	14.00
15.00	01500	290,887	1,623,200	138,360	34,291	0	15.00
16.00	01600	227,016	1,266,792	107,980	37,843	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,164,800	6,499,793	554,036	574,591	98,002	30.00
31.00	03100	403,599	2,252,155	191,971	128,435	26,385	31.00
43.00	04300	56,786	316,874	27,010	12,296	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	662,028	3,694,234	314,893	239,151	96,117	50.00
51.00	05100	192,305	1,073,098	91,470	11,271	0	51.00
52.00	05200	140,130	781,951	66,653	47,024	45,231	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	618,584	3,451,809	294,229	178,123	38,473	54.00
54.01	05401	0	0	0	0	0	54.01
54.02	05402	386,374	2,156,036	183,778	161,237	4,774	54.02
56.00	05600	78,346	437,184	37,265	6,981	0	56.00
57.00	05700	137,405	766,744	65,356	26,463	0	57.00
58.00	05800	152,630	851,704	72,598	45,795	0	58.00
60.00	06000	741,300	4,136,588	352,599	81,889	0	60.00
65.00	06500	172,691	963,649	82,140	41,300	0	65.00
66.00	06600	492,390	2,747,626	234,205	120,662	29,320	66.00
67.00	06700	49,134	274,175	23,370	0	0	67.00
68.00	06800	5,269	29,401	2,506	1,366	0	68.00
69.00	06900	22,779	127,112	10,835	683	0	69.00
71.00	07100	108,340	604,555	51,532	0	0	71.00
72.00	07200	503,044	2,807,077	239,272	0	0	72.00
73.00	07300	1,281,942	7,153,408	609,770	0	0	73.00
76.00	03020	0	0	0	0	0	76.00
76.01	03021	0	0	0	0	0	76.01
76.02	03022	0	0	0	0	0	76.02
76.03	03023	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	204,200	1,139,473	97,128	52,024	7,539	90.00
91.00	09100	546,447	3,049,271	259,917	183,069	52,769	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
96.00	09600	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	0	0	0	116.00
118.00		11,122,815	62,067,248	4,867,997	2,134,269	413,687	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	17,683	98,674	8,411	8,402	0	190.00
192.00	19200	652,668	3,642,007	0	1,559,765	7,806	192.00
192.01	19201	63,938	356,786	30,412	161,114	13,103	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	106,548	594,555	50,679	28,567	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		11,963,652	66,759,270	4,957,499	3,892,117	434,596	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet 8
Part 1
Date/Time Prepared:
7/30/2014 1:13 pm

Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00560						5.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	1,271,534	674,338				10.00
11.00	01100	26,697		1,055,118			11.00
13.00	01300	22,429	0	36,445	1,654,187		13.00
14.00	01400	5,811	0	23,912	37,831	1,016,480	14.00
15.00	01500	15,429	0	33,400	0	19,141	15.00
16.00	01600	19,267	0	42,664	0	1,602	16.00
16.00	01600	21,263	0				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000						30.00
31.00	03100	322,839	376,839	213,383	495,314	60,895	31.00
43.00	04300	72,163	43,447	65,646	185,598	19,136	43.00
43.00	04300	6,908	0	8,879	26,994	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000						50.00
51.00	05100	134,370	17,976	69,845	207,306	155,017	51.00
52.00	05200	6,333	0	33,048	97,424	14,248	52.00
53.00	05300	26,421	65,224	20,803	63,171	0	53.00
54.00	05400	0	0	0	0	0	54.00
54.01	05401	100,081	0	97,636	0	20,111	54.01
54.02	05402	0	0	0	0	0	54.02
56.00	05600	90,593	0	38,272	121,118	9,936	56.00
57.00	05700	3,922	0	6,539	0	240	57.00
58.00	05800	14,869	0	14,168	0	13,881	58.00
60.00	06000	25,730	0	14,136	0	918	60.00
65.00	06500	46,010	0	97,412	0	94,984	65.00
66.00	06600	23,205	0	33,208	80,794	5,028	66.00
67.00	06700	43,424	0	52,857	0	5,875	67.00
68.00	06800	0	0	2,853	0	714	68.00
69.00	06900	768	0	0	0	0	69.00
71.00	07100	384	0	6,795	12,362	490	71.00
72.00	07200	0	0	0	0	83,355	72.00
73.00	07300	0	0	0	0	432,464	73.00
76.00	03020	0	0	0	0	0	76.00
76.01	03021	0	0	0	0	0	76.01
76.02	03022	0	0	0	0	0	76.02
76.03	03023	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000						90.00
91.00	09100	28,463	0	44,972	100,198	19,707	91.00
92.00	09200	102,859	0	86,417	226,077	52,709	92.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
96.00	09600	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	0	0	0	116.00
118.00		1,160,238	503,486	1,043,290	1,654,187	1,010,451	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	4,721	0	3,141	0	763	190.00
192.00	19200	0	0	0	0	325	192.00
192.01	19201	90,524	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	16,051	0	8,687	0	4,941	194.01
194.02	07952	0	65,077	0	0	0	194.02
194.03	07953	0	105,775	0	0	0	194.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,271,534	674,338	1,055,118	1,654,187	1,016,480	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet B
Part I
Date/Time Prepared:
7/30/2014 1:13 pm

Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		15.00	16.00	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
2.00	00200						2.00	
4.00	00400						4.00	
5.01	00510						5.01	
5.02	00560						5.02	
7.00	00700						7.00	
8.00	00800						8.00	
9.00	00900						9.00	
10.00	01000						10.00	
11.00	01100						11.00	
13.00	01300						13.00	
14.00	01400						14.00	
15.00	01500	1,867,659					15.00	
16.00	01600		1,478,144				16.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	0	121,296	9,316,988	0	9,316,988	30.00	
31.00	03100	0	7,244	2,992,180	0	2,992,180	31.00	
43.00	04300	0	3,839	402,800	0	402,800	43.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	0	167,241	5,096,150	0	5,096,150	50.00	
51.00	05100	0	15,771	1,342,663	0	1,342,663	51.00	
52.00	05200	0	8,984	1,125,462	0	1,125,462	52.00	
53.00	05300	0	0	0	0	0	53.00	
54.00	05400	0	57,838	4,238,300	0	4,238,300	54.00	
54.01	05401	0	0	0	0	0	54.01	
54.02	05402	0	28,106	2,793,850	0	2,793,850	54.02	
56.00	05600	0	17,990	510,121	0	510,121	56.00	
57.00	05700	0	161,443	1,062,924	0	1,062,924	57.00	
58.00	05800	0	40,199	1,051,080	0	1,051,080	58.00	
60.00	06000	0	158,895	4,968,377	0	4,968,377	60.00	
65.00	06500	0	28,496	1,257,820	0	1,257,820	65.00	
66.00	06600	0	24,196	3,258,165	0	3,258,165	66.00	
67.00	06700	0	4,133	305,245	0	305,245	67.00	
68.00	06800	0	506	34,547	0	34,547	68.00	
69.00	06900	0	7,575	166,236	0	166,236	69.00	
71.00	07100	0	43,223	782,665	0	782,665	71.00	
72.00	07200	0	49,244	3,528,057	0	3,528,057	72.00	
73.00	07300	1,867,659	417,014	10,047,851	0	10,047,851	73.00	
76.00	03020	0	0	0	0	0	76.00	
76.01	03021	0	0	0	0	0	76.01	
76.02	03022	0	0	0	0	0	76.02	
76.03	03023	0	0	0	0	0	76.03	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	0	15,661	1,505,165	0	1,505,165	90.00	
91.00	09100	0	99,250	4,112,338	0	4,112,338	91.00	
92.00	09200	0	0	0	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	0	0	0	0	0	95.00	
96.00	09600	0	0	0	0	0	96.00	
SPECIAL PURPOSE COST CENTERS								
116.00	11600	0	0	0	0	0	116.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)		1,867,659	1,478,144	59,898,984	0	59,898,984	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	0	0	124,112	0	124,112	190.00	
192.00	19200	0	0	5,209,903	0	5,209,903	192.00	
192.01	19201	0	0	651,939	0	651,939	192.01	
194.00	07950	0	0	0	0	0	194.00	
194.01	07951	0	0	703,480	0	703,480	194.01	
194.02	07952	0	0	65,077	0	65,077	194.02	
194.03	07953	0	0	105,775	0	105,775	194.03	
200.00	Cross Foot Adjustments		0	0	0	0	200.00	
201.00	Negative Cost Centers		0	0	0	0	201.00	
202.00	TOTAL (sum lines 118-201)		1,867,659	1,478,144	66,759,270	0	66,759,270	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet B
Part II
Date/Time Prepared:
7/30/2014 1:13 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	15,312	8,701	24,013	24,013	4.00
5.01 00510	ADMINISTRATIVE & GENERAL	286,163	162,607	448,770	2,002	5.01
5.02 00560	OTHER ADMINISTRATIVE AND GENERAL	459,647	261,186	720,833	2,226	5.02
7.00 00700	OPERATION OF PLANT	473,107	268,834	741,941	522	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	9,501	5,399	14,900	0	8.00
9.00 00900	HOUSEKEEPING	18,938	10,761	29,699	629	9.00
10.00 01000	DIETARY	55,073	31,294	86,367	175	10.00
11.00 01100	CAFETERIA	46,269	26,291	72,560	511	11.00
13.00 01300	NURSING ADMINISTRATION	11,987	6,811	18,798	913	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	31,828	18,085	49,913	257	14.00
15.00 01500	PHARMACY	39,745	22,584	62,329	865	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	43,862	24,924	68,786	478	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	665,972	378,426	1,044,398	3,372	30.00
31.00 03100	INTENSIVE CARE UNIT	148,861	84,588	233,449	1,263	31.00
43.00 04300	NURSERY	14,251	8,098	22,349	184	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	277,185	157,505	434,690	1,411	50.00
51.00 05100	RECOVERY ROOM	13,064	7,423	20,487	663	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	54,503	30,970	85,473	430	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	206,452	117,312	323,764	1,665	54.00
54.01 05401	ULTRASOUND	0	0	0	0	54.01
54.02 05402	ONCOLOGY	186,880	106,191	293,071	824	54.02
56.00 05600	RADIOISOTOPE	8,091	4,598	12,689	139	56.00
57.00 05700	CT SCAN	30,672	17,429	48,101	254	57.00
58.00 05800	MRI	53,078	30,160	83,238	277	58.00
60.00 06000	LABORATORY	94,913	53,932	148,845	1,261	60.00
65.00 06500	RESPIRATORY THERAPY	47,868	27,200	75,068	550	65.00
66.00 06600	PHYSICAL THERAPY	139,851	79,468	219,319	640	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	25	67.00
68.00 06800	SPEECH PATHOLOGY	1,583	900	2,483	0	68.00
69.00 06900	ELECTROCARDIOLOGY	792	450	1,242	84	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03020	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	76.00
76.01 03021	SLEEP LAB	0	0	0	0	76.01
76.02 03022	PSYCH ANCILLARY SERVICES	0	0	0	0	76.02
76.03 03023	WOUND CARE	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	60,298	34,263	94,561	682	90.00
91.00 09100	EMERGENCY	212,184	120,569	332,753	1,539	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS						
116.00 11600	HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,707,930	2,106,959	5,814,889	23,841	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,738	5,534	15,272	33	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	1,807,821	1,027,263	2,835,084	0	192.00
192.01 19201	WELLNESS CENTER	186,738	106,110	292,848	0	192.01
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01 07951	MARKETING	33,110	18,814	51,924	139	194.01
194.02 07952	SENIOR CIRCLE	0	0	0	0	194.02
194.03 07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.03
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	5,745,337	3,264,680	9,010,017	24,013	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet B
Part II
Date/Time Prepared:
7/30/2014 1:13 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.01	5.02	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510	450,772					5.01
5.02	00560	33,472	756,531				5.02
7.00	00700	24,215	46,652	813,330			7.00
8.00	00800	2,653	5,111	1,713	24,377		8.00
9.00	00900	7,809	15,045	3,414	0	56,596	9.00
10.00	01000	3,734	7,193	9,929	0	1,188	10.00
11.00	01100	6,177	11,900	8,342	0	998	11.00
13.00	01300	9,964	19,197	2,161	0	259	13.00
14.00	01400	5,579	10,749	5,738	846	687	14.00
15.00	01500	10,960	21,115	7,166	0	858	15.00
16.00	01600	8,553	16,478	7,908	0	946	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	43,886	84,549	120,071	5,496	14,370	30.00
31.00	03100	15,206	29,296	26,839	1,480	3,212	31.00
43.00	04300	2,139	4,122	2,569	0	307	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	24,943	48,055	49,975	5,391	5,981	50.00
51.00	05100	7,245	13,959	2,355	0	282	51.00
52.00	05200	5,280	10,172	9,827	2,537	1,176	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	23,306	44,901	37,222	2,158	4,455	54.00
54.01	05401	0	0	0	0	0	54.01
54.02	05402	14,557	28,046	33,694	268	4,032	54.02
56.00	05600	2,952	5,687	1,459	0	175	56.00
57.00	05700	5,177	9,974	5,530	0	662	57.00
58.00	05800	5,751	11,079	9,570	0	1,145	58.00
60.00	06000	27,930	53,809	17,112	0	2,048	60.00
65.00	06500	6,506	12,535	8,630	0	1,033	65.00
66.00	06600	18,552	35,741	25,214	1,645	1,933	66.00
67.00	06700	1,851	3,566	0	0	0	67.00
68.00	06800	199	382	285	0	34	68.00
69.00	06900	858	1,653	143	0	17	69.00
71.00	07100	4,082	7,864	0	0	0	71.00
72.00	07200	18,953	36,514	0	0	0	72.00
73.00	07300	48,322	93,041	0	0	0	73.00
76.00	03020	0	0	0	0	0	76.00
76.01	03021	0	0	0	0	0	76.01
76.02	03022	0	0	0	0	0	76.02
76.03	03023	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	7,694	14,822	10,871	423	1,267	90.00
91.00	09100	20,588	39,665	38,256	2,960	4,578	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
96.00	09600	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	0	0	0	116.00
118.00		419,093	742,872	445,993	23,204	51,643	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	666	1,284	1,756	0	210	190.00
192.00	19200	24,590	0	325,943	438	0	192.00
192.01	19201	2,409	4,641	33,668	735	4,029	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	4,014	7,734	5,970	0	714	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		450,772	756,531	813,330	24,377	56,596	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet B
Part II
Date/Time Prepared:
7/30/2014 1:13 pm

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00560						5.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	108,586					10.00
11.00	01100	0	100,488				11.00
13.00	01300	0	3,471	54,763			13.00
14.00	01400	0	2,277	1,252	77,298		14.00
15.00	01500	0	3,181	0	1,456	107,930	15.00
16.00	01600	0	4,063	0	122	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	60,680	20,324	16,401	4,631	0	30.00
31.00	03100	6,996	6,252	6,144	1,455	0	31.00
43.00	04300	0	846	894	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,895	6,652	6,862	11,789	0	50.00
51.00	05100	0	3,147	3,225	1,084	0	51.00
52.00	05200	10,503	1,981	2,091	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	9,299	0	1,529	0	54.00
54.01	05401	0	0	0	0	0	54.01
54.02	05402	0	3,645	4,009	756	0	54.02
56.00	05600	0	623	0	18	0	56.00
57.00	05700	0	1,349	0	1,056	0	57.00
58.00	05800	0	1,346	0	70	0	58.00
60.00	06000	0	9,277	0	7,223	0	60.00
65.00	06500	0	3,163	2,675	382	0	65.00
66.00	06600	0	5,034	0	447	0	66.00
67.00	06700	0	272	0	54	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	647	409	37	0	69.00
71.00	07100	0	0	0	6,339	0	71.00
72.00	07200	0	0	0	32,884	0	72.00
73.00	07300	0	0	0	0	107,930	73.00
76.00	03020	0	0	0	0	0	76.00
76.01	03021	0	0	0	0	0	76.01
76.02	03022	0	0	0	0	0	76.02
76.03	03023	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	4,283	3,317	1,499	0	90.00
91.00	09100	0	8,230	7,484	4,008	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
96.00	09600	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	0	0	0	116.00
118.00		81,074	99,362	54,763	76,839	107,930	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	299	0	58	0	190.00
192.00	19200	0	0	0	25	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	827	0	376	0	194.01
194.02	07952	10,479	0	0	0	0	194.02
194.03	07953	17,033	0	0	0	0	194.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		108,586	100,488	54,763	77,298	107,930	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet B
Part II
Date/Time Prepared:
7/30/2014 1:13 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00510	ADMINISTRATIVE & GENERAL				5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL				5.02
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	107,334			16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,824	1,427,002	0	1,427,002
31.00	03100	INTENSIVE CARE UNIT	527	332,119	0	332,119
43.00	04300	NURSERY	279	33,689	0	33,689
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,166	610,810	0	610,810
51.00	05100	RECOVERY ROOM	1,147	53,594	0	53,594
52.00	05200	DELIVERY ROOM & LABOR ROOM	654	130,124	0	130,124
53.00	05300	ANESTHESIOLOGY	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,207	452,506	0	452,506
54.01	05401	ULTRASOUND	0	0	0	0
54.02	05402	ONCOLOGY	2,044	384,946	0	384,946
56.00	05600	RADIOISOTOPE	1,309	25,051	0	25,051
57.00	05700	CT SCAN	11,744	83,847	0	83,847
58.00	05800	MRI	2,924	115,400	0	115,400
60.00	06000	LABORATORY	11,559	279,064	0	279,064
65.00	06500	RESPIRATORY THERAPY	2,073	112,615	0	112,615
66.00	06600	PHYSICAL THERAPY	1,760	310,285	0	310,285
67.00	06700	OCCUPATIONAL THERAPY	301	6,069	0	6,069
68.00	06800	SPEECH PATHOLOGY	37	3,420	0	3,420
69.00	06900	ELECTROCARDIOLOGY	551	5,641	0	5,641
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,144	21,429	0	21,429
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,582	91,933	0	91,933
73.00	07300	DRUGS CHARGED TO PATIENTS	30,143	279,436	0	279,436
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0
76.01	03021	SLEEP LAB	0	0	0	0
76.02	03022	PSYCH ANCILLARY SERVICES	0	0	0	0
76.03	03023	WOUND CARE	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,139	140,558	0	140,558
91.00	09100	EMERGENCY	7,220	467,281	0	467,281
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0	
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	107,334	5,366,819	0	5,366,819
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,578	0	19,578
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,186,080	0	3,186,080
192.01	19201	WELLNESS CENTER	0	338,330	0	338,330
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0
194.01	07951	MARKETING	0	71,698	0	71,698
194.02	07952	SENIOR CIRCLE	0	10,479	0	10,479
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	17,033	0	17,033
200.00		Cross Foot Adjustments	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	107,334	9,010,017	0	9,010,017

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	362,834				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		362,834			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	967	967	22,569,570		4.00
5.01 00510	ADMINISTRATIVE & GENERAL	18,072	18,072	1,881,742	-11,963,652	5.01
5.02 00560	OTHER ADMINISTRATIVE AND GENERAL	29,028	29,028	2,092,240	0	5.02
7.00 00700	OPERATION OF PLANT	29,878	29,878	490,743	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	600	600	0	0	8.00
9.00 00900	HOUSEKEEPING	1,196	1,196	591,262	0	9.00
10.00 01000	DIETARY	3,478	3,478	164,560	0	10.00
11.00 01100	CAFETERIA	2,922	2,922	480,220	0	11.00
13.00 01300	NURSING ADMINISTRATION	757	757	858,122	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	2,010	2,010	241,994	0	14.00
15.00 01500	PHARMACY	2,510	2,510	813,414	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,770	2,770	449,581	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	42,058	42,058	3,168,382	0	30.00
31.00 03100	INTENSIVE CARE UNIT	9,401	9,401	1,187,210	0	31.00
43.00 04300	NURSERY	900	900	172,673	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	17,505	17,505	1,326,068	0	50.00
51.00 05100	RECOVERY ROOM	825	825	623,191	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,442	3,442	404,084	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	13,038	13,038	1,564,506	0	54.00
54.01 05401	ULTRASOUND	0	0	0	0	54.01
54.02 05402	ONCOLOGY	11,802	11,802	774,782	0	54.02
56.00 05600	RADIOISOTOPE	511	511	130,658	0	56.00
57.00 05700	CT SCAN	1,937	1,937	238,650	0	57.00
58.00 05800	MRI	3,352	3,352	260,036	0	58.00
60.00 06000	LABORATORY	5,994	5,994	1,185,478	0	60.00
65.00 06500	RESPIRATORY THERAPY	3,023	3,023	516,812	0	65.00
66.00 06600	PHYSICAL THERAPY	8,832	8,832	601,860	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	23,165	0	67.00
68.00 06800	SPEECH PATHOLOGY	100	100	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	50	50	79,077	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03020	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	76.00
76.01 03021	SLEEP LAB	0	0	0	0	76.01
76.02 03022	PSYCH ANCILLARY SERVICES	0	0	0	0	76.02
76.03 03023	WOUND CARE	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	3,808	3,808	640,935	0	90.00
91.00 09100	EMERGENCY	13,400	13,400	1,446,143	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS						
116.00 11600	HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	234,166	234,166	22,407,588	-11,963,652	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	615	615	31,184	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	114,169	114,169	0	0	192.00
192.01 19201	WELLNESS CENTER	11,793	11,793	0	0	192.01
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01 07951	MARKETING	2,091	2,091	130,798	0	194.01
194.02 07952	SENIOR CIRCLE	0	0	0	0	194.02
194.03 07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.03
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per wkst. B, Part I)	5,745,337	3,264,680	4,019,187		202.00
203.00	Unit cost multiplier (wkst. B, Part I)	15.834616	8.997723	0.178080		203.00
204.00	Cost to be allocated (per wkst. B, Part II)			24,013		204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet B-1

Date/Time Prepared:
7/30/2014 1:13 pm

Cost Center Description	CAPITAL RELATED COSTS			Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)			
	1.00	2.00	4.00			
205.00 Unit cost multiplier (wkst. B, Part II)			0.001064	5A.01	5.01	0.008226 205.00

Cost Center Description		Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5A.02	5.02	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00560	-4,957,499	58,159,764				5.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500						15.00
16.00	01600						16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000						30.00
31.00	03100						31.00
43.00	04300						43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000						50.00
51.00	05100						51.00
52.00	05200						52.00
53.00	05300						53.00
54.00	05400						54.00
54.01	05401						54.01
54.02	05402						54.02
56.00	05600						56.00
57.00	05700						57.00
58.00	05800						58.00
60.00	06000						60.00
65.00	06500						65.00
66.00	06600						66.00
67.00	06700						67.00
68.00	06800						68.00
69.00	06900						69.00
71.00	07100						71.00
72.00	07200						72.00
73.00	07300						73.00
76.00	03020						76.00
76.01	03021						76.01
76.02	03022						76.02
76.03	03023						76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000						90.00
91.00	09100						91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500						95.00
96.00	09600						96.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600						116.00
118.00							118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000						190.00
192.00	19200						192.00
192.01	19201						192.01
194.00	07950						194.00
194.01	07951						194.01
194.02	07952						194.02
194.03	07953						194.03
200.00							200.00
201.00							201.00
202.00							202.00
203.00							203.00
204.00							204.00
205.00							205.00
SUBTOTALS (SUM OF LINES 1-117)		-4,957,499	57,109,749	156,221	511,811	151,150	
190.00	19000		98,674	615	0	615	190.00
192.00	19200	-3,642,007	0	114,169	9,657	0	192.00
192.01	19201		356,786	11,793	16,211	11,793	192.01
194.00	07950		0	0	0	0	194.00
194.01	07951		594,555	2,091	0	2,091	194.01
194.02	07952		0	0	0	0	194.02
194.03	07953		0	0	0	0	194.03
200.00							200.00
201.00							201.00
202.00			4,957,499	3,892,117	434,596	1,271,534	202.00
203.00			0.085239	13.661872	0.808282	7.676074	203.00
204.00			756,531	813,330	24,377	56,596	204.00
205.00			0.013008	2.854901	0.045337	0.341662	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet B-1

Date/Time Prepared:
7/30/2014 1:13 pm

Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00560						5.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	101,321					10.00
11.00	01100	0	32,917				11.00
13.00	01300	0	1,137	10,581,320			13.00
14.00	01400	0	746	241,994	5,415,456		14.00
15.00	01500	0	1,042	0	101,975	5,871,466	15.00
16.00	01600	0	1,331	0	8,535	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	56,621	6,657	3,168,382	324,427	0	30.00
31.00	03100	6,528	2,048	1,187,210	101,949	0	31.00
43.00	04300	0	277	172,673	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,701	2,179	1,326,068	825,876	0	50.00
51.00	05100	0	1,031	623,191	75,909	0	51.00
52.00	05200	9,800	649	404,084	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	3,046	0	107,142	0	54.00
54.01	05401	0	0	0	0	0	54.01
54.02	05402	0	1,194	774,752	52,937	0	54.02
56.00	05600	0	204	0	1,276	0	56.00
57.00	05700	0	442	0	73,952	0	57.00
58.00	05800	0	441	0	4,890	0	58.00
60.00	06000	0	3,039	0	506,040	0	60.00
65.00	06500	0	1,036	516,812	26,789	0	65.00
66.00	06600	0	1,649	0	31,298	0	66.00
67.00	06700	0	89	0	3,803	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	212	79,077	2,610	0	69.00
71.00	07100	0	0	0	444,087	0	71.00
72.00	07200	0	0	0	2,304,033	0	72.00
73.00	07300	0	0	0	0	5,871,466	73.00
76.00	03020	0	0	0	0	0	76.00
76.01	03021	0	0	0	0	0	76.01
76.02	03022	0	0	0	0	0	76.02
76.03	03023	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	1,403	640,934	104,993	0	90.00
91.00	09100	0	2,696	1,446,143	280,816	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
96.00	09600	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	0	0	0	116.00
118.00		75,650	32,548	10,581,320	5,383,337	5,871,466	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	98	0	4,067	0	190.00
192.00	19200	0	0	0	1,730	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	271	0	26,322	0	194.01
194.02	07952	9,778	0	0	0	0	194.02
194.03	07953	15,893	0	0	0	0	194.03
200.00							200.00
201.00							201.00
202.00		674,338	1,055,118	1,654,187	1,016,480	1,867,659	202.00
203.00		6.655461	32.053893	0.156331	0.187700	0.318091	203.00
204.00		108,586	100,488	54,763	77,298	107,930	204.00
205.00		1.071703	3.052769	0.005175	0.014274	0.018382	205.00

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		16.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00510	ADMINISTRATIVE & GENERAL	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	5.02
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
		438,872,174	
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
		36,014,320	
		2,150,778	
		1,139,874	
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	ULTRASOUND	54.01
54.02	05402	ONCOLOGY	54.02
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	76.00
76.01	03021	SLEEP LAB	76.01
76.02	03022	PSYCH ANCILLARY SERVICES	76.02
76.03	03023	WOUND CARE	76.03
		49,655,884	
		4,682,596	
		2,667,490	
		0	
		17,172,825	
		0	
		8,344,883	
		5,341,422	
		47,934,246	
		11,935,486	
		47,177,918	
		8,460,863	
		7,184,229	
		1,227,179	
		150,124	
		2,248,983	
		12,833,434	
		14,621,235	
		123,809,998	
		0	
		0	
		0	
		0	
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
		4,649,902	
		29,468,505	
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	96.00
		0	
		0	
SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
		438,872,174	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	WELLNESS CENTER	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	194.00
194.01	07951	MARKETING	194.01
194.02	07952	SENIOR CIRCLE	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	194.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per wkst. B, Part I)	202.00
		1,478,144	
203.00		Unit cost multiplier (wkst. B, Part I)	203.00
204.00		Cost to be allocated (per wkst. B, Part II)	204.00
		0.003368	
205.00		Unit cost multiplier (wkst. B, Part II)	205.00
		107,334	
		0.000245	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet C
Part I
Date/Time Prepared:
7/30/2014 1:13 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII		Hospital		
				Total Costs	RCE	Costs Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	PPS	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,316,988		9,316,988	0	9,316,988	30.00
31.00	03100	INTENSIVE CARE UNIT	2,992,180		2,992,180	0	2,992,180	31.00
43.00	04300	NURSERY	402,800		402,800	0	402,800	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,096,150		5,096,150	0	5,096,150	50.00
51.00	05100	RECOVERY ROOM	1,342,663		1,342,663	0	1,342,663	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,125,462		1,125,462	0	1,125,462	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,238,300		4,238,300	0	4,238,300	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
54.02	05402	ONCOLOGY	2,793,850		2,793,850	0	2,793,850	54.02
56.00	05600	RADIOISOTOPE	510,121		510,121	0	510,121	56.00
57.00	05700	CT SCAN	1,062,924		1,062,924	0	1,062,924	57.00
58.00	05800	MRI	1,051,080		1,051,080	0	1,051,080	58.00
60.00	06000	LABORATORY	4,968,377		4,968,377	0	4,968,377	60.00
65.00	06500	RESPIRATORY THERAPY	1,257,820	0	1,257,820	0	1,257,820	65.00
66.00	06600	PHYSICAL THERAPY	3,258,165	0	3,258,165	0	3,258,165	66.00
67.00	06700	OCCUPATIONAL THERAPY	305,245	0	305,245	0	305,245	67.00
68.00	06800	SPEECH PATHOLOGY	34,547	0	34,547	0	34,547	68.00
69.00	06900	ELECTROCARDIOLOGY	166,236		166,236	0	166,236	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	782,665		782,665	0	782,665	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,528,057		3,528,057	0	3,528,057	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,047,851		10,047,851	0	10,047,851	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0		0	0	0	76.00
76.01	03021	SLEEP LAB	0		0	0	0	76.01
76.02	03022	PSYCH ANCILLARY SERVICES	0		0	0	0	76.02
76.03	03023	WOUND CARE	0		0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,505,165		1,505,165	0	1,505,165	90.00
91.00	09100	EMERGENCY	4,112,338		4,112,338	0	4,112,338	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,714,014		1,714,014	0	1,714,014	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0		0	0	0	116.00
200.00		Subtotal (see instructions)	61,612,998	0	61,612,998	0	61,612,998	200.00
201.00		Less Observation Beds	1,714,014		1,714,014	0	1,714,014	201.00
202.00		Total (see instructions)	59,898,984	0	59,898,984	0	59,898,984	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet c
Part I
Date/Time Prepared:
7/30/2014 1:13 pm

Cost Center Description	Charges			Hospital Cost or Other Ratio	TEFRA Inpatient Ratio	PPS
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	30,614,786		30,614,786			30.00
31.00 03100 INTENSIVE CARE UNIT	2,150,778		2,150,778			31.00
43.00 04300 NURSERY	1,139,874		1,139,874			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	16,068,442	33,587,442	49,655,884	0.102629	0.000000	50.00
51.00 05100 RECOVERY ROOM	1,573,380	3,109,216	4,682,596	0.286735	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2,361,856	305,634	2,667,490	0.421918	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	4,884,027	12,288,798	17,172,825	0.246803	0.000000	54.00
54.01 05401 ULTRASOUND	0	0	0	0.000000	0.000000	54.01
54.02 05402 ONCOLOGY	194,227	8,150,656	8,344,883	0.334798	0.000000	54.02
56.00 05600 RADIOISOTOPE	259,886	5,081,536	5,341,422	0.095503	0.000000	56.00
57.00 05700 CT SCAN	6,412,294	41,521,952	47,934,246	0.022175	0.000000	57.00
58.00 05800 MRI	587,803	11,347,683	11,935,486	0.088063	0.000000	58.00
60.00 06000 LABORATORY	13,674,232	33,503,686	47,177,918	0.105311	0.000000	60.00
65.00 06500 RESPIRATORY THERAPY	3,929,903	4,530,960	8,460,863	0.148663	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	871,736	6,312,493	7,184,229	0.453516	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	40,424	1,186,755	1,227,179	0.248737	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	57,016	93,108	150,124	0.230123	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	106,278	2,142,705	2,248,983	0.073916	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5,125,210	7,708,224	12,833,434	0.060986	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	8,193,301	6,427,934	14,621,235	0.241297	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	43,671,050	80,138,948	123,809,998	0.081155	0.000000	73.00
76.00 03020 OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.00
76.01 03021 SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.02 03022 PSYCH ANCILLARY SERVICES	0	0	0	0.000000	0.000000	76.02
76.03 03023 WOUND CARE	0	0	0	0.000000	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	446,664	4,203,238	4,649,902	0.323698	0.000000	90.00
91.00 09100 EMERGENCY	5,440,831	24,027,674	29,468,505	0.139550	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1,308,053	4,091,481	5,399,534	0.317437	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
SPECIAL PURPOSE COST CENTERS						
116.00 11600 HOSPICE	0	0	0			116.00
200.00	Subtotal (see instructions)	149,112,051	289,760,123	438,872,174		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	149,112,051	289,760,123	438,872,174		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet C
Part I
Date/Time Prepared:
7/30/2014 1:13 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.102629			50.00
51.00	05100 RECOVERY ROOM	0.286735			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.421918			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.246803			54.00
54.01	05401 ULTRASOUND	0.000000			54.01
54.02	05402 ONCOLOGY	0.334798			54.02
56.00	05600 RADIOISOTOPE	0.095503			56.00
57.00	05700 CT SCAN	0.022175			57.00
58.00	05800 MRI	0.088063			58.00
60.00	06000 LABORATORY	0.105311			60.00
65.00	06500 RESPIRATORY THERAPY	0.148663			65.00
66.00	06600 PHYSICAL THERAPY	0.453516			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.248737			67.00
68.00	06800 SPEECH PATHOLOGY	0.230123			68.00
69.00	06900 ELECTROCARDIOLOGY	0.073916			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.060986			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.241297			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.081155			73.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTER	0.000000			76.00
76.01	03021 SLEEP LAB	0.000000			76.01
76.02	03022 PSYCH ANCILLARY SERVICES	0.000000			76.02
76.03	03023 WOUND CARE	0.000000			76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.323698			90.00
91.00	09100 EMERGENCY	0.139550			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.317437			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000			96.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600 HOSPICE				116.00
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: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet C
Part I
Date/Time Prepared:
7/30/2014 1:13 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital		Cost
				Total Costs	RCE	Costs		
						Total Costs	Disallowance	
1.00	2.00	3.00	4.00	5.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,316,988		9,316,988	0	9,316,988	30.00
31.00	03100	INTENSIVE CARE UNIT	2,992,180		2,992,180	0	2,992,180	31.00
43.00	04300	NURSERY	402,800		402,800	0	402,800	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,096,150		5,096,150	0	5,096,150	50.00
51.00	05100	RECOVERY ROOM	1,342,663		1,342,663	0	1,342,663	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,125,462		1,125,462	0	1,125,462	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,238,300		4,238,300	0	4,238,300	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
54.02	05402	ONCOLOGY	2,793,850		2,793,850	0	2,793,850	54.02
56.00	05600	RADIOISOTOPE	510,121		510,121	0	510,121	56.00
57.00	05700	CT SCAN	1,062,924		1,062,924	0	1,062,924	57.00
58.00	05800	MRI	1,051,080		1,051,080	0	1,051,080	58.00
60.00	06000	LABORATORY	4,968,377		4,968,377	0	4,968,377	60.00
65.00	06500	RESPIRATORY THERAPY	1,257,820	0	1,257,820	0	1,257,820	65.00
66.00	06600	PHYSICAL THERAPY	3,258,165	0	3,258,165	0	3,258,165	66.00
67.00	06700	OCCUPATIONAL THERAPY	305,245	0	305,245	0	305,245	67.00
68.00	06800	SPEECH PATHOLOGY	34,547	0	34,547	0	34,547	68.00
69.00	06900	ELECTROCARDIOLOGY	166,236		166,236	0	166,236	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	782,665		782,665	0	782,665	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,528,057		3,528,057	0	3,528,057	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,047,851		10,047,851	0	10,047,851	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0		0	0	0	76.00
76.01	03021	SLEEP LAB	0		0	0	0	76.01
76.02	03022	PSYCH ANCILLARY SERVICES	0		0	0	0	76.02
76.03	03023	WOUND CARE	0		0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,505,165		1,505,165	0	1,505,165	90.00
91.00	09100	EMERGENCY	4,112,338		4,112,338	0	4,112,338	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,714,014		1,714,014		1,714,014	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	61,612,998	0	61,612,998	0	61,612,998	200.00
201.00		Less Observation Beds	1,714,014		1,714,014		1,714,014	201.00
202.00		Total (see instructions)	59,898,984	0	59,898,984	0	59,898,984	202.00

Cost Center Description	Charges			Hospital Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	30,614,786		30,614,786			30.00
31.00 03100 INTENSIVE CARE UNIT	2,150,778		2,150,778			31.00
43.00 04300 NURSERY	1,139,874		1,139,874			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	16,068,442	33,587,442	49,655,884	0.102629	0.000000	50.00
51.00 05100 RECOVERY ROOM	1,573,380	3,109,216	4,682,596	0.286735	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2,361,856	305,634	2,667,490	0.421918	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	4,884,027	12,288,798	17,172,825	0.246803	0.000000	54.00
54.01 05401 ULTRASOUND	0	0	0	0.000000	0.000000	54.01
54.02 05402 ONCOLOGY	194,227	8,150,656	8,344,883	0.334798	0.000000	54.02
56.00 05600 RADIOISOTOPE	259,886	5,081,536	5,341,422	0.095503	0.000000	56.00
57.00 05700 CT SCAN	6,412,294	41,521,952	47,934,246	0.022175	0.000000	57.00
58.00 05800 MRI	587,803	11,347,683	11,935,486	0.088063	0.000000	58.00
60.00 06000 LABORATORY	13,674,232	33,503,686	47,177,918	0.105311	0.000000	60.00
65.00 06500 RESPIRATORY THERAPY	3,929,903	4,530,960	8,460,863	0.148663	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	871,736	6,312,493	7,184,229	0.453516	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	40,424	1,186,755	1,227,179	0.248737	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	57,016	93,108	150,124	0.230123	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	106,278	2,142,705	2,248,983	0.073916	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5,125,210	7,708,224	12,833,434	0.060986	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	8,193,301	6,427,934	14,621,235	0.241297	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	43,671,050	80,138,948	123,809,998	0.081155	0.000000	73.00
76.00 03020 OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.00
76.01 03021 SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.02 03022 PSYCH ANCILLARY SERVICES	0	0	0	0.000000	0.000000	76.02
76.03 03023 WOUND CARE	0	0	0	0.000000	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	446,664	4,203,238	4,649,902	0.323698	0.000000	90.00
91.00 09100 EMERGENCY	5,440,831	24,027,674	29,468,505	0.139550	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1,308,053	4,091,481	5,399,534	0.317437	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
SPECIAL PURPOSE COST CENTERS						
116.00 11600 HOSPICE	0	0	0			116.00
200.00 Subtotal (see instructions)	149,112,051	289,760,123	438,872,174			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	149,112,051	289,760,123	438,872,174			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet c
Part I
Date/Time Prepared:
7/30/2014 1:13 pm

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
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401 ULTRASOUND	0.000000			54.01
54.02	05402 ONCOLOGY	0.000000			54.02
56.00	05600 RADIOISOTOPE	0.000000			56.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MRI	0.000000			58.00
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
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTER	0.000000			76.00
76.01	03021 SLEEP LAB	0.000000			76.01
76.02	03022 PSYCH ANCILLARY SERVICES	0.000000			76.02
76.03	03023 WOUND CARE	0.000000			76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000			96.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600 HOSPICE				116.00
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: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet c
Part I
Date/Time Prepared:
7/30/2014 1:13 pm

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title V		Hospital	
			Total Costs	RCE	Costs	Total Costs
				Disallowance		
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	9,316,988		9,316,988	0	9,316,988	30.00
31.00 03100 INTENSIVE CARE UNIT	2,992,180		2,992,180	0	2,992,180	31.00
43.00 04300 NURSERY	402,800		402,800	0	402,800	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	5,096,150		5,096,150	0	5,096,150	50.00
51.00 05100 RECOVERY ROOM	1,342,663		1,342,663	0	1,342,663	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1,125,462		1,125,462	0	1,125,462	52.00
53.00 05300 ANESTHESIOLOGY	0		0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	4,238,300		4,238,300	0	4,238,300	54.00
54.01 05401 ULTRASOUND	0		0	0	0	54.01
54.02 05402 ONCOLOGY	2,793,850		2,793,850	0	2,793,850	54.02
56.00 05600 RADIOISOTOPE	510,121		510,121	0	510,121	56.00
57.00 05700 CT SCAN	1,062,924		1,062,924	0	1,062,924	57.00
58.00 05800 MRI	1,051,080		1,051,080	0	1,051,080	58.00
60.00 06000 LABORATORY	4,968,377		4,968,377	0	4,968,377	60.00
65.00 06500 RESPIRATORY THERAPY	1,257,820	0	1,257,820	0	1,257,820	65.00
66.00 06600 PHYSICAL THERAPY	3,258,165	0	3,258,165	0	3,258,165	66.00
67.00 06700 OCCUPATIONAL THERAPY	305,245	0	305,245	0	305,245	67.00
68.00 06800 SPEECH PATHOLOGY	34,547	0	34,547	0	34,547	68.00
69.00 06900 ELECTROCARDIOLOGY	166,236		166,236	0	166,236	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	782,665		782,665	0	782,665	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	3,528,057		3,528,057	0	3,528,057	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	10,047,851		10,047,851	0	10,047,851	73.00
76.00 03020 OTHER ANCILLARY SERVICE COST CENTER	0		0	0	0	76.00
76.01 03021 SLEEP LAB	0		0	0	0	76.01
76.02 03022 PSYCH ANCILLARY SERVICES	0		0	0	0	76.02
76.03 03023 WOUND CARE	0		0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	1,505,165		1,505,165	0	1,505,165	90.00
91.00 09100 EMERGENCY	4,112,338		4,112,338	0	4,112,338	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1,714,014		1,714,014	0	1,714,014	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0		0	0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
SPECIAL PURPOSE COST CENTERS						
116.00 11600 HOSPICE	0		0	0	0	116.00
200.00 Subtotal (see instructions)	61,612,998	0	61,612,998	0	61,612,998	200.00
201.00 Less Observation Beds	1,714,014		1,714,014	0	1,714,014	201.00
202.00 Total (see instructions)	59,898,984	0	59,898,984	0	59,898,984	202.00

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet C
Part I
Date/Time Prepared:
7/30/2014 1:13 pm

Cost Center Description	Title V			Hospital	Cost	
	Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	30,614,786		30,614,786			30.00
31.00 03100 INTENSIVE CARE UNIT	2,150,778		2,150,778			31.00
43.00 04300 NURSERY	1,139,874		1,139,874			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	16,068,442	33,587,442	49,655,884	0.102629	0.000000	50.00
51.00 05100 RECOVERY ROOM	1,573,380	3,109,216	4,682,596	0.286735	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2,361,856	305,634	2,667,490	0.421918	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	4,884,027	12,288,798	17,172,825	0.246803	0.000000	54.00
54.01 05401 ULTRASOUND	0	0	0	0.000000	0.000000	54.01
54.02 05402 ONCOLOGY	194,227	8,150,656	8,344,883	0.334798	0.000000	54.02
56.00 05600 RADIOISOTOPE	259,886	5,081,536	5,341,422	0.095503	0.000000	56.00
57.00 05700 CT SCAN	6,412,294	41,521,952	47,934,246	0.022175	0.000000	57.00
58.00 05800 MRI	587,803	11,347,683	11,935,486	0.088063	0.000000	58.00
60.00 06000 LABORATORY	13,674,232	33,503,686	47,177,918	0.105311	0.000000	60.00
65.00 06500 RESPIRATORY THERAPY	3,929,903	4,530,960	8,460,863	0.148663	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	871,736	6,312,493	7,184,229	0.453516	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	40,424	1,186,755	1,227,179	0.248737	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	57,016	93,108	150,124	0.230123	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	106,278	2,142,705	2,248,983	0.073916	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5,125,210	7,708,224	12,833,434	0.060986	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	8,193,301	6,427,934	14,621,235	0.241297	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	43,671,050	80,138,948	123,809,998	0.081155	0.000000	73.00
76.00 03020 OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.00
76.01 03021 SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.02 03022 PSYCH ANCILLARY SERVICES	0	0	0	0.000000	0.000000	76.02
76.03 03023 WOUND CARE	0	0	0	0.000000	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	446,664	4,203,238	4,649,902	0.323698	0.000000	90.00
91.00 09100 EMERGENCY	5,440,831	24,027,674	29,468,505	0.139550	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1,308,053	4,091,481	5,399,534	0.317437	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
SPECIAL PURPOSE COST CENTERS						
116.00 11600 HOSPICE	0	0	0			116.00
200.00 Subtotal (see instructions)	149,112,051	289,760,123	438,872,174			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	149,112,051	289,760,123	438,872,174			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet C
Part I
Date/Time Prepared:
7/30/2014 1:13 pm

Cost Center Description		PPS Inpatient Ratio	Title V	Hospital	Cost
INPATIENT ROUTINE SERVICE COST CENTERS		11.00			
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401 ULTRASOUND	0.000000			54.01
54.02	05402 ONCOLOGY	0.000000			54.02
56.00	05600 RADIOISOTOPE	0.000000			56.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MRI	0.000000			58.00
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
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTER	0.000000			76.00
76.01	03021 SLEEP LAB	0.000000			76.01
76.02	03022 PSYCH ANCILLARY SERVICES	0.000000			76.02
76.03	03023 WOUND CARE	0.000000			76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000			96.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600 HOSPICE				116.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	1,427,002	0	1,427,002	12,910	110.53	30.00	
31.00	INTENSIVE CARE UNIT	332,119		332,119	987	336.49	31.00	
43.00	NURSERY	33,689		33,689	1,194	28.22	43.00	
200.00	Total (lines 30-199)	1,792,810		1,792,810	15,091		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	3,904	431,509					30.00
31.00	INTENSIVE CARE UNIT	343	115,416					31.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30-199)	4,247	546,925					200.00

Cost Center Description	Capital Related Cost (From Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 - col. 2)	Hospital Inpatient Program Charges	PPS	
					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	610,810	49,655,884	0.012301	3,767,558	46,345	50.00
51.00 05100 RECOVERY ROOM	53,594	4,682,596	0.011445	364,471	4,171	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	130,124	2,667,490	0.048781	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	452,506	17,172,825	0.026350	2,463,248	64,907	54.00
54.01 05401 ULTRASOUND	0	0	0.000000	0	0	54.01
54.02 05402 ONCOLOGY	384,946	8,344,883	0.046130	152,257	7,024	54.02
56.00 05600 RADIOISOTOPE	25,051	5,341,422	0.004690	112,998	530	56.00
57.00 05700 CT SCAN	83,847	47,934,246	0.001749	3,092,043	5,408	57.00
58.00 05800 MRI	115,400	11,935,486	0.009669	280,414	2,711	58.00
60.00 06000 LABORATORY	279,064	47,177,918	0.005915	5,674,182	33,563	60.00
65.00 06500 RESPIRATORY THERAPY	112,615	8,460,863	0.013310	1,733,951	23,079	65.00
66.00 06600 PHYSICAL THERAPY	310,285	7,184,229	0.043190	349,297	15,086	66.00
67.00 06700 OCCUPATIONAL THERAPY	6,069	1,227,179	0.004945	21,779	108	67.00
68.00 06800 SPEECH PATHOLOGY	3,420	150,124	0.022781	39,072	890	68.00
69.00 06900 ELECTROCARDIOLOGY	5,641	2,248,983	0.002508	25,469	64	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	21,429	12,833,434	0.001670	1,580,257	2,639	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	91,933	14,621,235	0.006288	2,731,304	17,174	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	279,436	123,809,998	0.002257	15,918,132	35,927	73.00
76.00 03020 OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76.00
76.01 03021 SLEEP LAB	0	0	0.000000	0	0	76.01
76.02 03022 PSYCH ANCILLARY SERVICES	0	0	0.000000	0	0	76.02
76.03 03023 WOUND CARE	0	0	0.000000	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	140,558	4,649,902	0.030228	60,081	1,816	90.00
91.00 09100 EMERGENCY	467,281	29,468,505	0.015857	2,109,751	33,454	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	262,520	5,399,534	0.048619	435,283	21,163	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00 Total (lines 50-199)	3,836,529	404,966,736		40,911,547	316,059	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS Provider CCN: 150133 Period: From 03/01/2013 To 02/28/2014 Worksheet D Part III Date/Time Prepared: 7/30/2014 1:13 pm

Cost Center Description		Title XVIII			Hospital	PPS	Total Costs (sum of cols. 1 through 3, minus col. 4)
		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0 30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
43.00	04300	NURSERY	0	0	0	0	0 43.00
200.00		Total (lines 30-199)	0	0	0	0	0 200.00
Cost Center Description		Total Patient Days	Per Diem (col. 5 - col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
		6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,910	0.00	3,904	0	30.00
31.00	03100	INTENSIVE CARE UNIT	987	0.00	343	0	31.00
43.00	04300	NURSERY	1,194	0.00	0	0	43.00
200.00		Total (lines 30-199)	15,091		4,247	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet D
Part IV
Date/Time Prepared:
7/30/2014 1:13 pm

Cost Center Description	Title XVIII			Hospital	PPS
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	0	0	0	0 50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
54.01 05401 ULTRASOUND	0	0	0	0	0 54.01
54.02 05402 ONCOLOGY	0	0	0	0	0 54.02
56.00 05600 RADIOISOTOPE	0	0	0	0	0 56.00
57.00 05700 CT SCAN	0	0	0	0	0 57.00
58.00 05800 MRI	0	0	0	0	0 58.00
60.00 06000 LABORATORY	0	0	0	0	0 60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00 03020 OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0 76.00
76.01 03021 SLEEP LAB	0	0	0	0	0 76.01
76.02 03022 PSYCH ANCILLARY SERVICES	0	0	0	0	0 76.02
76.03 03023 WOUND CARE	0	0	0	0	0 76.03
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0	0	0	0	0 90.00
91.00 09100 EMERGENCY	0	0	0	0	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES	0	0	0	0	0 95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0 96.00
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: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet D
Part IV
Date/Time Prepared:
7/30/2014 1:13 pm

Cost Center Description	Title XVIII				Hospital	
	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)	PPS Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	49,655,884	0.000000	0.000000	3,767,558	50.00
51.00 05100 RECOVERY ROOM	0	4,682,596	0.000000	0.000000	364,471	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	2,667,490	0.000000	0.000000	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	17,172,825	0.000000	0.000000	2,463,248	54.00
54.01 05401 ULTRASOUND	0	0	0.000000	0.000000	0	54.01
54.02 05402 ONCOLOGY	0	8,344,883	0.000000	0.000000	152,257	54.02
56.00 05600 RADIOISOTOPE	0	5,341,422	0.000000	0.000000	112,998	56.00
57.00 05700 CT SCAN	0	47,934,246	0.000000	0.000000	3,092,043	57.00
58.00 05800 MRI	0	11,935,486	0.000000	0.000000	280,414	58.00
60.00 06000 LABORATORY	0	47,177,918	0.000000	0.000000	5,674,182	60.00
65.00 06500 RESPIRATORY THERAPY	0	8,460,863	0.000000	0.000000	1,733,951	65.00
66.00 06600 PHYSICAL THERAPY	0	7,184,229	0.000000	0.000000	349,297	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	1,227,179	0.000000	0.000000	21,779	67.00
68.00 06800 SPEECH PATHOLOGY	0	150,124	0.000000	0.000000	39,072	68.00
69.00 06900 ELECTROCARDIOLOGY	0	2,248,983	0.000000	0.000000	25,469	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	12,833,434	0.000000	0.000000	1,580,257	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	14,621,235	0.000000	0.000000	2,731,304	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	123,809,998	0.000000	0.000000	15,918,132	73.00
76.00 03020 OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0.000000	0	76.00
76.01 03021 SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.02 03022 PSYCH ANCILLARY SERVICES	0	0	0.000000	0.000000	0	76.02
76.03 03023 WOUND CARE	0	0	0.000000	0.000000	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	4,649,902	0.000000	0.000000	60,081	90.00
91.00 09100 EMERGENCY	0	29,468,505	0.000000	0.000000	2,109,751	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	5,399,534	0.000000	0.000000	435,283	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0	0	0.000000	0.000000	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00 Total (lines 50-199)	0	404,966,736			40,911,547	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet D
Part IV
Date/Time Prepared:
7/30/2014 1:13 pm

Cost Center Description		Title XVIII			Hospital	PPS
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,220,909	0	50.00
51.00	05100	RECOVERY ROOM	0	379,680	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	176	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,679,903	0	54.00
54.01	05401	ULTRASOUND	0	0	0	54.01
54.02	05402	ONCOLOGY	0	3,656,876	0	54.02
56.00	05600	RADIOISOTOPE	0	1,338,942	0	56.00
57.00	05700	CT SCAN	0	7,373,402	0	57.00
58.00	05800	MRI	0	2,172,349	0	58.00
60.00	06000	LABORATORY	0	1,384,818	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	917,959	0	65.00
66.00	06600	PHYSICAL THERAPY	0	4,359	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,118	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	641,974	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,012,834	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,213,829	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,806,681	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	76.00
76.01	03021	SLEEP LAB	0	0	0	76.01
76.02	03022	PSYCH ANCILLARY SERVICES	0	0	0	76.02
76.03	03023	WOUND CARE	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	759,950	0	90.00
91.00	09100	EMERGENCY	0	3,580,266	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	918,569	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00		Total (lines 50-199)	0	56,064,594	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet D
Part V
Date/Time Prepared:
7/30/2014 1:13 pm

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
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.102629	5,220,909	0	0	535,817 50.00
51.00 05100 RECOVERY ROOM	0.286735	379,680	0	0	108,868 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.421918	176	0	0	74 52.00
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.246803	4,679,903	0	0	1,155,014 54.00
54.01 05401 ULTRASOUND	0.000000	0	0	0	0 54.01
54.02 05402 ONCOLOGY	0.334798	3,656,876	0	0	1,224,315 54.02
56.00 05600 RADIOISOTOPE	0.095503	1,338,942	0	0	127,873 56.00
57.00 05700 CT SCAN	0.022175	7,373,402	0	0	163,505 57.00
58.00 05800 MRI	0.088063	2,172,349	0	0	191,304 58.00
60.00 06000 LABORATORY	0.105311	1,384,818	7,167	0	145,837 60.00
65.00 06500 RESPIRATORY THERAPY	0.148663	917,959	0	0	136,467 65.00
66.00 06600 PHYSICAL THERAPY	0.453516	4,359	0	0	1,977 66.00
67.00 06700 OCCUPATIONAL THERAPY	0.248737	1,118	0	0	278 67.00
68.00 06800 SPEECH PATHOLOGY	0.230123	0	0	0	0 68.00
69.00 06900 ELECTROCARDIOLOGY	0.073916	641,974	0	0	47,452 69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.060986	1,012,834	344	0	61,769 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.241297	1,213,829	0	0	292,893 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.081155	20,806,681	0	77,944	1,688,566 73.00
76.00 03020 OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0 76.00
76.01 03021 SLEEP LAB	0.000000	0	0	0	0 76.01
76.02 03022 PSYCH ANCILLARY SERVICES	0.000000	0	0	0	0 76.02
76.03 03023 WOUND CARE	0.000000	0	0	0	0 76.03
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0.323698	759,950	0	0	245,994 90.00
91.00 09100 EMERGENCY	0.139550	3,580,266	0	0	499,626 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.317437	918,569	0	0	291,588 92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES	0.000000	0	0	0	0 95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0 96.00
200.00 Subtotal (see instructions)		56,064,594	7,511	77,944	6,919,217 200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00 Net Charges (line 200 +/- line 201)		56,064,594	7,511	77,944	6,919,217 202.00

		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
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	ULTRASOUND	0	0	54.01
54.02	05402	ONCOLOGY	0	0	54.02
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	755	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,326	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0	0	76.00
76.01	03021	SLEEP LAB	0	0	76.01
76.02	03022	PSYCH ANCILLARY SERVICES	0	0	76.02
76.03	03023	WOUND CARE	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	776	6,326	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)	776	6,326	202.00

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Hospital		Cost
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs PPS Services (see inst.)	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.102629	0	2,692,621	0	0 50.00
51.00	05100 RECOVERY ROOM	0.286735	0	308,577	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.421918	0	152,512	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.246803	0	2,745,025	0	0 54.00
54.01	05401 ULTRASOUND	0.000000	0	0	0	0 54.01
54.02	05402 ONCOLOGY	0.334798	0	434,802	0	0 54.02
56.00	05600 RADIOISOTOPE	0.095503	0	272,856	0	0 56.00
57.00	05700 CT SCAN	0.022175	0	5,760,827	0	0 57.00
58.00	05800 MRI	0.088063	0	1,110,089	0	0 58.00
60.00	06000 LABORATORY	0.105311	0	4,419,762	0	0 60.00
65.00	06500 RESPIRATORY THERAPY	0.148663	0	492,724	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.453516	0	315,047	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.248737	0	21,918	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.230123	0	6,689	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.073916	0	105,172	0	0 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.060986	0	569,795	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.241297	0	387,607	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.081155	0	9,605,567	0	0 73.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0 76.00
76.01	03021 SLEEP LAB	0.000000	0	0	0	0 76.01
76.02	03022 PSYCH ANCILLARY SERVICES	0.000000	0	0	0	0 76.02
76.03	03023 WOUND CARE	0.000000	0	0	0	0 76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.323698	0	211,032	0	0 90.00
91.00	09100 EMERGENCY	0.139550	0	5,578,615	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.317437	0	480,590	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0.000000	0	0	0	0 95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0 96.00
200.00	Subtotal (see instructions)		0	35,671,827	0	0 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00	Net Charges (line 200 +/- line 201)		0	35,671,827	0	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet D
Part V
Date/Time Prepared:
7/30/2014 1:13 pm

		Costs		
Cost Center Description		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Cost
		6.00	7.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	276,341	0	50.00
51.00	05100 RECOVERY ROOM	88,480	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	64,348	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	677,480	0	54.00
54.01	05401 ULTRASOUND	0	0	54.01
54.02	05402 ONCOLOGY	145,571	0	54.02
56.00	05600 RADIOISOTOPE	26,059	0	56.00
57.00	05700 CT SCAN	127,746	0	57.00
58.00	05800 MRI	97,758	0	58.00
60.00	06000 LABORATORY	465,450	0	60.00
65.00	06500 RESPIRATORY THERAPY	73,250	0	65.00
66.00	06600 PHYSICAL THERAPY	142,879	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	5,452	0	67.00
68.00	06800 SPEECH PATHOLOGY	1,539	0	68.00
69.00	06900 ELECTROCARDIOLOGY	7,774	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	34,750	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	93,528	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	779,540	0	73.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTER	0	0	76.00
76.01	03021 SLEEP LAB	0	0	76.01
76.02	03022 PSYCH ANCILLARY SERVICES	0	0	76.02
76.03	03023 WOUND CARE	0	0	76.03
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	68,311	0	90.00
91.00	09100 EMERGENCY	778,496	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	152,557	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00	Subtotal (see instructions)	4,107,309	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)	4,107,309	0	202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet D-1

Date/Time Prepared:
7/30/2014 1:13 pm

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)			12,910 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			12,910 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)			10,535 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			3,904 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)			9,316,988 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)			9,316,988 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)			9,316,988 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)			721.69 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,817,478 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)			2,817,478 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet D-1

Date/Time Prepared:
7/30/2014 1:13 pm

Cost Center Description	Title XVIII			Hospital	PPS	
	Total	Total	Average Per	Program Days	Program Cost	
	Inpatient Cost	Inpatient Days	Diem (col. 1 - col. 2)		(col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	2,992,180	987	3,031.59	343	1,039,835	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						
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					1.00	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,783,467	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)					546,925	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					316,059	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					862,984	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					7,777,796	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 + line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					2,375	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					721.69	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,714,014	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet D-1
Date/Time Prepared:
7/30/2014 1:13 pm

Cost Center Description	Title XVIII			Hospital	PPS	
	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	1,427,002	9,316,988	0.153161	1,714,014	262,520	90.00
91.00 Nursing School cost	0	9,316,988	0.000000	1,714,014	0	91.00
92.00 Allied health cost	0	9,316,988	0.000000	1,714,014	0	92.00
93.00 All other Medical Education	0	9,316,988	0.000000	1,714,014	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet D-3

Date/Time Prepared:
7/30/2014 1:13 pm

Cost Center Description		Title XVIII Hospital		
		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		7,684,107	30.00
31.00	03100 INTENSIVE CARE UNIT		1,013,964	31.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.102629	3,767,558	50.00
51.00	05100 RECOVERY ROOM	0.286735	364,471	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.421918	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.246803	2,463,248	54.00
54.01	05401 ULTRASOUND	0.000000	0	54.01
54.02	05402 ONCOLOGY	0.334798	152,257	54.02
56.00	05600 RADIOISOTOPE	0.095503	112,998	56.00
57.00	05700 CT SCAN	0.022175	3,092,043	57.00
58.00	05800 MRI	0.088063	280,414	58.00
60.00	06000 LABORATORY	0.105311	5,674,182	60.00
65.00	06500 RESPIRATORY THERAPY	0.148663	1,733,951	65.00
66.00	06600 PHYSICAL THERAPY	0.453516	349,297	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.248737	21,779	67.00
68.00	06800 SPEECH PATHOLOGY	0.230123	39,072	68.00
69.00	06900 ELECTROCARDIOLOGY	0.073916	25,469	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.060986	1,580,257	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.241297	2,731,304	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.081155	15,918,132	73.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	76.00
76.01	03021 SLEEP LAB	0.000000	0	76.01
76.02	03022 PSYCH ANCILLARY SERVICES	0.000000	0	76.02
76.03	03023 WOUND CARE	0.000000	0	76.03
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.323698	60,081	90.00
91.00	09100 EMERGENCY	0.139550	2,109,751	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.317437	435,283	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES			95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		40,911,547	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)		40,911,547	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet D-3

Date/Time Prepared:
7/30/2014 1:13 pm

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		2,426,225		30.00
31.00	03100 INTENSIVE CARE UNIT		365,812		31.00
43.00	04300 NURSERY		573,728		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.102629	1,976,557	202,852	50.00
51.00	05100 RECOVERY ROOM	0.286735	235,680	67,578	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.421918	968,066	408,444	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.246803	496,220	122,469	54.00
54.01	05401 ULTRASOUND	0.000000	0	0	54.01
54.02	05402 ONCOLOGY	0.334798	37,538	12,568	54.02
56.00	05600 RADIOISOTOPE	0.095503	38,492	3,676	56.00
57.00	05700 CT SCAN	0.022175	759,529	16,843	57.00
58.00	05800 MRI	0.088063	35,650	3,139	58.00
60.00	06000 LABORATORY	0.105311	1,684,145	177,359	60.00
65.00	06500 RESPIRATORY THERAPY	0.148663	387,752	57,644	65.00
66.00	06600 PHYSICAL THERAPY	0.453516	106,685	48,383	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.248737	1,759	438	67.00
68.00	06800 SPEECH PATHOLOGY	0.230123	1,961	451	68.00
69.00	06900 ELECTROCARDIOLOGY	0.073916	12,912	954	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.060986	530,049	32,326	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.241297	450,013	108,587	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.081155	5,340,695	433,424	73.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.01	03021 SLEEP LAB	0.000000	0	0	76.01
76.02	03022 PSYCH ANCILLARY SERVICES	0.000000	0	0	76.02
76.03	03023 WOUND CARE	0.000000	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.323698	57,095	18,482	90.00
91.00	09100 EMERGENCY	0.139550	583,559	81,436	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.317437	185,934	59,022	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		13,890,291	1,856,075	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)		13,890,291		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet E
Part A
Date/Time Prepared:
7/30/2014 1:13 pm

		Title XVIII		Hospital		PPS
		0	before 1/1	on/after 1/1	1.01	2.00
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS						
1.00	DRG Amounts Other than Outlier Payments		0			1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013 (see instructions)		3,781,169			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		2,700,835			1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI (see instructions)		0			1.03
2.00	Outlier payments for discharges. (see instructions)		113,224			2.00
2.01	Outlier reconciliation amount		0			2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0			2.02
3.00	Managed Care Simulated Payments		3,999,299			3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		65.49			4.00
Indirect Medical Education Adjustment						
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00			5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00			6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00			7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) if the cost report straddles July 1, 2011 then see instructions.		0.00			7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00			8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00			8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00			8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00			9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00			10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00			11.00
12.00	Current year allowable FTE (see instructions)		0.00			12.00
13.00	Total allowable FTE count for the prior year.		0.00			13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00			14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00			15.00
16.00	Adjustment for residents in initial years of the program		0.00			16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00			17.00
18.00	Adjusted rolling average FTE count		0.00			18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000			19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000			20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000			21.00
22.00	IME payment adjustment (see instructions)		0			22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00			23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00			24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00			25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000			26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000			27.00
28.00	IME add-on adjustment amount (see instructions)		0			28.00
29.00	Total IME payment (sum of lines 22 and 28)		0			29.00
Disproportionate Share Adjustment						
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.01			30.00
31.00	Percentage of Medicaid patient days (see instructions)		18.13			31.00
32.00	Sum of lines 30 and 31		20.14			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet E
Part A
Date/Time Prepared:
7/30/2014 1:13 pm

		Title XVIII		Hospital	PPS	
		0	before 1/1	on/after 1/1	2.00	
33.00	Allowable disproportionate share percentage (see instructions)		5.84			33.00
34.00	Disproportionate share adjustment (see instructions)		260,252			34.00
			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
Uncompensated Care Adjustment						
35.00	Total uncompensated care amount (see instructions)				9,046,380,143	35.00
35.01	Factor 3 (see instructions)				0.000072798	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)				658,555	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)				272,444	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		272,444			36.00
Additional payment for high percentage of ESRD beneficiary discharges						
40.00	Total Medicare discharges on worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0			40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0		41.00
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)		7,127,924			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)		7,127,924			49.00
50.00	Payment for inpatient program capital (from worksheet L, Parts I, II, as applicable)		534,685			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)		7,662,609			59.00
60.00	Primary payer payments		0			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		7,662,609			61.00
62.00	Deductibles billed to program beneficiaries		925,280			62.00
63.00	Coinurance billed to program beneficiaries		1,776			63.00
64.00	Allowable bad debts (see instructions)		129,113			64.00
65.00	Adjusted reimbursable bad debts (see instructions)		83,923			65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		108,967			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		6,819,476			67.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150133	Period: From 03/01/2013 To 02/28/2014	Worksheet E Part A Date/Time Prepared: 7/30/2014 1:13 pm
		Title XVIII	Hospital	PPS
		0	Prior to October 1 1.00	On/After October 1 2.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0	68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00			0	70.00
70.50	RURAL DEMONSTRATION PROJECT		0	70.50
70.92	Bundled Model 1 discount amount		0	70.92
70.93	HVBP incentive payment (see instructions)		4,865	70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		-10,697	70.94
70.95	Recovery of Accelerated Depreciation		0	70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		6,813,644	71.00
71.01	Sequestration adjustment (see instructions)		124,690	71.01
72.00	Interim payments		6,646,690	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		42,264	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		1,324,562	75.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Operating outlier amount from worksheet E, Part A line 2 (see instructions)		0	90.00
91.00	Capital outlier from worksheet L, Part I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the Time Value of Money		0.00	94.00
95.00	Time Value of Money for operating expenses(see instructions)		0	95.00
96.00	Time Value of Money for capital related expenses (see instructions)		0	96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150133	Period: From 03/01/2013 To 02/28/2014	Worksheet E Part B Date/Time Prepared: 7/30/2014 1:13 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		7,102	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		6,919,217	2.00
3.00	PPS payments		6,431,574	3.00
4.00	Outlier payment (see instructions)		6,369	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)		7,102	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		85,455	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)		85,455	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)		85,455	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		78,353	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)		7,102	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)		6,437,943	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		69	25.00
26.00	Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)		1,404,844	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)		5,040,132	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)		5,040,132	30.00
31.00	Primary payer payments		1,814	31.00
32.00	Subtotal (line 30 minus line 31)		5,038,318	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)		218,186	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		141,821	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		197,523	36.00
37.00	Subtotal (see instructions)		5,180,139	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		5,180,139	40.00
40.01	Sequestration adjustment (see instructions)		94,797	40.01
41.00	Interim payments		4,991,588	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		93,754	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: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet E-1
Part I
Date/Time Prepared:
7/30/2014 1:13 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		6,646,690		4,964,988	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) Program to Provider					3.00
3.01	ADJUSTMENTS TO PROVIDER		0	09/26/2013	26,600	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		26,600	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)		6,646,690		4,991,588	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) Program to Provider					5.00
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		42,264		93,754	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		6,688,954		5,085,342	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet E-1
Part II
Date/Time Prepared:
7/30/2014 1:13 pm

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1.00	Total hospital discharges as defined in AARA §4102 from wkst S-3, Part I column 15 line 14	3,509	1.00
2.00	Medicare days from wkst S-3, Part I, column 6 sum of lines 1, 8-12	4,247	2.00
3.00	Medicare HMO days from wkst S-3, Part I, column 6. line 2	2,591	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	11,522	4.00
5.00	Total hospital charges from wkst C, Part I, column 8 line 200	438,872,174	5.00
6.00	Total hospital charity care charges from wkst S-10, column 3 line 20	1,161,584	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)	1,103,130	8.00
9.00	Sequestration adjustment amount (see instructions)	22,063	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1,081,067	10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30.00	Initial/interim HIT payment adjustment (see instructions)	1,138,148	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)	-57,081	32.00

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

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet G

Date/Time Prepared:
7/30/2014 1:13 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	-532,978	0	0	0	1.00
2.00 Temporary investments	0	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	30,895,441	0	0	0	4.00
5.00 Other receivable	0	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-9,318,119	0	0	0	6.00
7.00 Inventory	1,881,500	0	0	0	7.00
8.00 Prepaid expenses	648,141	0	0	0	8.00
9.00 Other current assets	208,190	0	0	0	9.00
10.00 Due from other funds	0	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	23,782,175	0	0	0	11.00
FIXED ASSETS					
12.00 Land	2,769,169	0	0	0	12.00
13.00 Land improvements	1,048,140	0	0	0	13.00
14.00 Accumulated depreciation	-496,200	0	0	0	14.00
15.00 Buildings	35,711,333	0	0	0	15.00
16.00 Accumulated depreciation	-6,683,908	0	0	0	16.00
17.00 Leasehold improvements	12,805,593	0	0	0	17.00
18.00 Accumulated depreciation	-2,451,161	0	0	0	18.00
19.00 Fixed equipment	2,232,209	0	0	0	19.00
20.00 Accumulated depreciation	-930,526	0	0	0	20.00
21.00 Automobiles and trucks	108,645	0	0	0	21.00
22.00 Accumulated depreciation	-74,325	0	0	0	22.00
23.00 Major movable equipment	18,247,660	0	0	0	23.00
24.00 Accumulated depreciation	-12,061,117	0	0	0	24.00
25.00 Minor equipment depreciable	5,135,855	0	0	0	25.00
26.00 Accumulated depreciation	-2,912,110	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)	52,449,257	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	0	0	0	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	0	0	0	0	33.00
34.00 Other assets	2,730,486	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	2,730,486	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	78,961,918	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	1,599,171	0	0	0	37.00
38.00 Salaries, wages, and fees payable	2,775,579	0	0	0	38.00
39.00 Payroll taxes payable	192,456	0	0	0	39.00
40.00 Notes and loans payable (short term)	0	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	-200,962,750	0	0	0	43.00
44.00 Other current liabilities	1,611,906	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	-194,783,638	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	0	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	2,439,304	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	2,439,304	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	-192,344,334	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	271,306,252	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	271,306,252	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	78,961,918	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet G-1
Date/Time Prepared:
7/30/2014 1:13 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		221,871,329			0	1.00
2.00	Net income (loss) (from wkst. G-3, line 29)		49,434,921				2.00
3.00	Total (sum of line 1 and line 2)		271,306,250			0	3.00
4.00	ROUNDING						4.00
5.00		2		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)		2			0	10.00
11.00	Subtotal (line 3 plus line 10)		271,306,252			0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		271,306,252			0	19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet G-2
Parts I & II
Date/Time Prepared:
7/30/2014 1:13 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	31,754,660		31,754,660	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	31,754,660		31,754,660	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	2,150,778		2,150,778	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	2,150,778		2,150,778	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	33,905,438		33,905,438	17.00
18.00	Ancillary services	108,011,065	257,437,730	365,448,795	18.00
19.00	Outpatient services	7,195,548	32,322,393	39,517,941	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	0	0	0	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	149,112,051	289,760,123	438,872,174	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		88,423,682		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)		88,423,682		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet G-3

Date/Time Prepared:
7/30/2014 1:13 pm

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	438,872,174	1.00
2.00	Less contractual allowances and discounts on patients' accounts	303,061,089	2.00
3.00	Net patient revenues (line 1 minus line 2)	135,811,085	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	88,423,682	4.00
5.00	Net income from service to patients (line 3 minus line 4)	47,387,403	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 INCOME	2,047,518	24.00
25.00	Total other income (sum of lines 6-24)	2,047,518	25.00
26.00	Total (line 5 plus line 25)	49,434,921	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	49,434,921	29.00

CALCULATION OF CAPITAL PAYMENT

Provider CCN: 150133

Period:
From 03/01/2013
To 02/28/2014

Worksheet L
Parts I-III
Date/Time Prepared:
7/30/2014 1:13 pm

		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		513,966	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		20,719	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		31.57	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		0	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		534,685	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