

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet S Parts I-III Date/Time Prepared: 2/26/2014 2:33 pm
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**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 2/26/2014 Time: 2:33 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by BLUFFTON REGIONAL MEDICAL CENTER ( 150075 ) for the cost reporting period beginning 10/01/2012 and ending 09/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

**Encryption Information**

**ECR:** Date: 2/26/2014 Time: 2:33 pm  
V9Stzj tCjj yeFyhj x. AYpFV4j qzpaO  
VP5Fz0anf: WMqgPEqsxs1w0BWUu1Fh  
mf4d1EGUyl OrygrD  
**PI:** Date: 2/26/2014 Time: 2:33 pm  
: f4VI i EPI RbNsej ENBQWF031Q: BKRO  
c9I cJ00UUNMhpNDuUbxAX3j wDKXxmaV  
cOG80YFFNw0oJoYd

(Signed)

Officer or Administrator of Provider(s)

Title

Date

	Title V 1.00	Title XVII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	-74,468	2,545	67,408	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	35	0	0	0	7.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
200.00 Total	0	-74,433	2,545	67,408	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: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet S-2 Part I Date/Time Prepared: 2/26/2014 2:00 pm
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		1.00	2.00	3.00	4.00					
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 303 S. MAIN STREET	PO Box:		Zip Code: 46714-		County: WELLS		1.00		
2.00	City: BLUFFTON	State: IN						2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		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	BLUFFTON REGIONAL MEDICAL CENTER	150075	23060	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	BLUFFTON SKILLED NURSING	155373	23060		03/13/1991	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					10/01/2012	09/30/2013		20.00	
21.00	Type of Control (see instructions)					4		21.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	763	0	4	0	490	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0		25.00	
						Urban/Rural	S	Date of Geogr		
						1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet S-2 Part I Date/Time Prepared: 2/26/2014 2:00 pm			
		Beginning: 1.00	Ending: 2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00		
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00		
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00		
		Y/N 1.00	Y/N 2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	Y		39.00		
		V 1.00	XVIII 2.00	XIX 3.00			
<b>Prospective Payment System (PPS)-Capital</b>							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00		
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00		
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00		
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00		
<b>Teaching Hospitals</b>							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00		
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00		
		Y/N 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN and general surgery) added as a result of section 5503. (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06
		Program Name 1.00		Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.				0.00	0.00	61.10

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20	
					1.00		
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 Nonprovi der Site	Unweighted FTEs in Hospi tal	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	Unwei ghted FTEs Nonprovi der Site	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 65.00	
			Unwei ghted FTEs Nonprovi der Site	Unwei ghted FTEs in Hospi tal	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: 150075		Period: From 10/01/2012 To 09/30/2013		Worksheet S-2 Part I Date/Time Prepared: 2/26/2014 2:00 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
<b>Inpatient Psychiatric Facility PPS</b>									
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00			
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	71.00			
<b>Inpatient Rehabilitation Facility PPS</b>									
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00			
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	76.00			
							1.00		
<b>Long Term Care Hospital PPS</b>									
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00			
<b>TEFRA Providers</b>									
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00			
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00			
							V	XIX	
							1.00	2.00	
<b>Title V and XIX Services</b>									
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00			
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00			
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00			
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00			
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	95.00		
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00			
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	97.00		
<b>Rural Providers</b>									
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			N		105.00			
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106.00			



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1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: CHS / COMMUNITY HEALTH SYSTEMS, INC.	Contractor's Name: WPS	Contractor's Number: 52280		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	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
					1.00		
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00
					1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.				Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)				0	168.00	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)				0.75	169.00	
		Beginning	Ending				
		1.00	2.00				
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		10/01/2012	09/30/2013	170.00		

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet S-2 Part II Date/Time Prepared: 2/26/2014 2:00 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		N		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		N		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.		N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
			Part A		Part B
			Y/N	Date	Y/N
			1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		Y	02/17/2014	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet S-2 Part II Date/Time Prepared: 2/26/2014 2:00 pm	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	1.00 2.00	3.00 N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			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
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
			Y/N 1.00	Date 2.00	
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		Y	12/31/2012	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
			1.00	2.00	
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RYAN	NELSON		41.00
42.00	Enter the employer/company name of the cost report preparer.	CHS/COMMUNITY HEALTH SYSTEMS, INC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(615) 465-7553	RYAN_NELSON@CHS.NET		43.00

		Part B		
		Date		
		4.00		
<b>PS&amp;R Data</b>				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	02/17/2014		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER, 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: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/26/2014 2:00 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	55	20,075	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)		55	20,075	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	7	2,555	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		62	22,630	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	13	4,745		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		75				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/26/2014 2:00 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,014	576	6,271			1.00
2.00 HMO and other (see instructions)	1,399	494				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	3,014	576	6,271			7.00
8.00 INTENSIVE CARE UNIT	422	32	801			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		155	504			13.00
14.00 Total (see instructions)	3,436	763	7,576	0.00	11.89	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	1,955	0	3,148	0.00	247.70	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	259.59	27.00
28.00 Observation Bed Days		0	1,431			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			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/26/2014 2:00 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	823	213	1,901	1.00
2.00	HMO and other (see instructions)			338			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	823	213	1,901	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 150075		Period: From 10/01/2012 To 09/30/2013		Worksheet S-3 Part II Date/Time Prepared: 2/26/2014 2:00 pm	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
<b>PART II - WAGE DATA</b>								
<b>SALARIES</b>								
1.00	Total salaries (see instructions)	200.00	13,166,819	0	13,166,819	539,992.00	24.38	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	546,546	0	546,546	24,724.00	22.11	9.00
10.00	Excluded area salaries (see instructions)		10,436	360,461	370,897	13,550.00	27.37	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>								
11.00	Contract labor (see instructions)		79,061	0	79,061	420.00	188.24	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		153,063	0	153,063	1,032.00	148.32	13.00
14.00	Home office salaries & wage-related costs		847,538	0	847,538	14,397.00	58.87	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
<b>WAGE-RELATED COSTS</b>								
17.00	Wage-related costs (core) (see instructions)		3,007,210	0	3,007,210			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		231,238	0	231,238			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26.00	Employee Benefits Department	4.00	140,665	70,645	211,310	6,608.00	31.98	26.00
27.00	Administrative & General	5.00	2,179,427	-241,357	1,938,070	27,025.00	71.71	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	497,526	0	497,526	21,933.00	22.68	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	286,075	0	286,075	26,533.00	10.78	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	444,020	-334,359	109,661	8,322.00	13.18	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	334,359	334,359	25,373.00	13.18	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	899,955	47,116	947,071	25,566.00	37.04	38.00
39.00	Central Services and Supply	14.00	132,675	0	132,675	5,503.00	24.11	39.00
40.00	Pharmacy	15.00	494,661	0	494,661	13,578.00	36.43	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet S-3  
Part II  
Date/Time Prepared:  
2/26/2014 2:00 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
41.00	Medical Records & Medical Records Library	16.00	395,578	0	395,578	21,366.00	18.51	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet S-3  
Part III  
Date/Time Prepared:  
2/26/2014 2:00 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	13,166,819	0	13,166,819	539,992.00	24.38	1.00
2.00	Excluded area salaries (see instructions)	556,982	360,461	917,443	38,274.00	23.97	2.00
3.00	Subtotal salaries (line 1 minus line 2)	12,609,837	-360,461	12,249,376	501,718.00	24.41	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,079,662	0	1,079,662	15,849.00	68.12	4.00
5.00	Subtotal wage-related costs (see inst.)	3,007,210	0	3,007,210	0.00	24.55	5.00
6.00	Total (sum of lines 3 thru 5)	16,696,709	-360,461	16,336,248	517,567.00	31.56	6.00
7.00	Total overhead cost (see instructions)	5,470,582	-123,596	5,346,986	181,807.00	29.41	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet S-3 Part IV Date/Time Prepared: 2/26/2014 2:00 pm
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions			320,656 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)			1,653,211 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			27,328 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			13,169 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			-208 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			8,650 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			160,291 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
<b>TAXES</b>				
17.00	FICA-Employers Portion Only			778,672 17.00
18.00	Medicare Taxes - Employers Portion Only			182,109 18.00
19.00	Unemployment Insurance			0 19.00
20.00	State or Federal Unemployment Taxes			94,849 20.00
<b>OTHER</b>				
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)			3,238,727 24.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER PAYROLL TAX			-189 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet S-3  
Part V  
Date/Time Prepared:  
2/26/2014 2:00 pm

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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet S-7

Date/Time Prepared:  
2/26/2014 2:00 pm

		1.00	2.00	3.00	4.00
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N			2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	3.00
4.00		RUL	0	0	4.00
5.00		RVX	0	0	5.00
6.00		RVL	0	0	6.00
7.00		RHX	0	0	7.00
8.00		RHL	0	0	8.00
9.00		RMX	0	0	9.00
10.00		RML	12	0	10.00
11.00		RLX	0	0	11.00
12.00		RUC	0	0	12.00
13.00		RUB	6	0	13.00
14.00		RUA	0	0	14.00
15.00		RVC	263	0	15.00
16.00		RVB	184	0	16.00
17.00		RVA	12	0	17.00
18.00		RHC	188	0	18.00
19.00		RHB	585	0	19.00
20.00		RHA	105	0	20.00
21.00		RMC	100	0	21.00
22.00		RMB	277	0	22.00
23.00		RMA	60	0	23.00
24.00		RLB	0	0	24.00
25.00		RLA	0	0	25.00
26.00		ES3	0	0	26.00
27.00		ES2	3	0	27.00
28.00		ES1	0	0	28.00
29.00		HE2	0	0	29.00
30.00		HE1	7	0	30.00
31.00		HD2	0	0	31.00
32.00		HD1	9	0	32.00
33.00		HC2	0	0	33.00
34.00		HC1	0	0	34.00
35.00		HB2	0	0	35.00
36.00		HB1	13	0	36.00
37.00		LE2	0	0	37.00
38.00		LE1	0	0	38.00
39.00		LD2	0	0	39.00
40.00		LD1	0	0	40.00
41.00		LC2	0	0	41.00
42.00		LC1	8	0	42.00
43.00		LB2	0	0	43.00
44.00		LB1	10	0	44.00
45.00		CE2	0	0	45.00
46.00		CE1	3	0	46.00
47.00		CD2	0	0	47.00
48.00		CD1	3	0	48.00
49.00		CC2	0	0	49.00
50.00		CC1	17	0	50.00
51.00		CB2	0	0	51.00
52.00		CB1	7	0	52.00
53.00		CA2	0	0	53.00
54.00		CA1	65	0	54.00
55.00		SE3	0	0	55.00
56.00		SE2	0	0	56.00
57.00		SE1	0	0	57.00
58.00		SSC	0	0	58.00
59.00		SSB	0	0	59.00
60.00		SSA	0	0	60.00
61.00		IB2	0	0	61.00
62.00		IB1	0	0	62.00
63.00		IA2	0	0	63.00
64.00		IA1	0	0	64.00
65.00		BB2	0	0	65.00
66.00		BB1	3	0	66.00
67.00		BA2	0	0	67.00
68.00		BA1	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet S-7

Date/Time Prepared:  
2/26/2014 2:00 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	7	0	7	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	7	0	7	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	1	0	1	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		1,955	0	1,955	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
201.00	SNF SERVICES	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).		23060	23060	201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		0	0.00		202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		2,330,978			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet S-10 Date/Time Prepared: 2/26/2014 2:00 pm
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				1.00	
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.210655		1.00
<b>Medicaid (see instructions for each line)</b>					
2.00	Net revenue from Medicaid		2,992,211		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0		5.00
6.00	Medicaid charges		15,683,508		6.00
7.00	Medicaid cost (line 1 times line 6)		3,303,809		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)		311,598		8.00
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>					
9.00	Net revenue from stand-alone SCHIP		0		9.00
10.00	Stand-alone SCHIP charges		0		10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0		11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00
<b>Other state or local government indigent care program (see instructions for each line)</b>					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		182,007		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		1,278,248		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		269,269		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)		87,262		16.00
<b>Uncompensated care (see instructions for each line)</b>					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		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)		398,860		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	205,721	20,221	225,942	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	43,336	4,260	47,596	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	43,336	4,260	47,596	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		3,304,901		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		45,982		27.00
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)		3,258,919		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		686,508		29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		734,104		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,132,964		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet A

Date/Time Prepared:  
2/26/2014 2:00 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		1,465,975	1,465,975	453,198	1,919,173	1.00
1.01	00101		0	0	0	0	1.01
2.00	00200		2,147,351	2,147,351	372,438	2,519,789	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	140,665	44,125	184,790	2,360,563	2,545,353	4.00
5.01	00510	0	0	0	311,404	311,404	5.01
5.02	00540	0	0	0	400,890	400,890	5.02
5.03	00550	0	0	0	4,366,577	4,366,577	5.03
5.04	00560	2,179,427	13,341,559	15,520,986	-8,397,316	7,123,670	5.04
7.00	00700	497,526	1,640,622	2,138,148	6,207	2,144,355	7.00
8.00	00800	0	164,698	164,698	0	164,698	8.00
9.00	00900	286,075	206,314	492,389	-16	492,373	9.00
10.00	01000	444,020	293,578	737,598	-556,044	181,554	10.00
11.00	01100	0	0	0	553,562	553,562	11.00
13.00	01300	899,955	236,849	1,136,804	33,637	1,170,441	13.00
14.00	01400	132,675	1,052,279	1,184,954	-669,885	515,069	14.00
15.00	01500	494,661	1,117,117	1,611,778	-1,017,325	594,453	15.00
16.00	01600	395,578	184,743	580,321	-8,820	571,501	16.00
17.00	01700	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	2,008,476	1,266,025	3,274,501	-460,945	2,813,556	30.00
31.00	03100	602,055	94,550	696,605	-5,119	691,486	31.00
43.00	04300	0	0	0	238,456	238,456	43.00
44.00	04400	546,546	106,221	652,767	-7,294	645,473	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	535,514	313,838	849,352	1,027,793	1,877,145	50.00
51.00	05100	303,788	58,957	362,745	-362,745	0	51.00
52.00	05200	0	0	0	187,785	187,785	52.00
53.00	05300	0	697,034	697,034	-697,034	0	53.00
54.00	05400	515,201	176,643	691,844	299,889	991,733	54.00
54.01	03630	108,255	4,466	112,721	-112,721	0	54.01
56.00	05600	64,814	70,319	135,133	0	135,133	56.00
57.00	05700	158,852	36,090	194,942	-194,942	0	57.00
58.00	05800	105,290	18,377	123,667	-123,667	0	58.00
60.00	06000	896,967	863,347	1,760,314	-391,525	1,368,789	60.00
65.00	06500	405,033	70,006	475,039	-1,177	473,862	65.00
66.00	06600	423,103	86,956	510,059	263,328	773,387	66.00
67.00	06700	175,305	17,929	193,234	-193,234	0	67.00
68.00	06800	66,406	6,367	72,773	-72,773	0	68.00
69.00	06900	39,653	77,161	116,814	0	116,814	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	173,616	173,616	71.00
72.00	07200	0	0	0	518,023	518,023	72.00
73.00	07300	0	0	0	939,365	939,365	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	75,042	12,130	87,172	-368	86,804	76.01
76.02	03952	0	0	0	0	0	76.02
76.03	03953	15,606	18,396	34,002	0	34,002	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	98	62	160	-160	0	88.00
90.00	09000	31,182	11,225	42,407	56,903	99,310	90.00
91.00	09100	608,615	166,831	775,446	259,445	1,034,891	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	262,178	262,178	-262,178	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		13,156,383	26,330,318	39,486,701	-712,209	38,774,492	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	9,343	34,593	43,936	0	43,936	190.00
192.00	19200	0	-3,153	-3,153	0	-3,153	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07955	0	0	0	403,949	403,949	194.01
194.02	07952	1,093	4,424	5,517	0	5,517	194.02
194.03	07953	0	0	0	308,260	308,260	194.03
194.04	07954	0	0	0	0	0	194.04
200.00		13,166,819	26,366,182	39,533,001	0	39,533,001	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet A  
Date/Time Prepared:  
2/26/2014 2:00 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-90,494	1,828,679	1.00
1.01	00101 WELLS CRC COSTS-BLDG & FIXT	145,796	145,796	1.01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	-615,550	1,904,239	2.00
3.00	00300 OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-5,076	2,540,277	4.00
5.01	00510 NONPATIENT TELEPHONES	-52,156	259,248	5.01
5.02	00540 ADMINITTING	0	400,890	5.02
5.03	00550 CASHIERING/ACCOUNTS RECEIVABLE	-3,563,607	802,970	5.03
5.04	00560 OTHER ADMINISTRATIVE AND GENERAL	-1,006,870	6,116,800	5.04
7.00	00700 OPERATION OF PLANT	0	2,144,355	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	-27,700	136,998	8.00
9.00	00900 HOUSEKEEPING	0	492,373	9.00
10.00	01000 DIETARY	0	181,554	10.00
11.00	01100 CAFETERIA	-21,924	531,638	11.00
13.00	01300 NURSING ADMINISTRATION	-28,202	1,142,239	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	515,069	14.00
15.00	01500 PHARMACY	-600	593,853	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-346	571,155	16.00
17.00	01700 SOCIAL SERVICE	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS	-715,686	2,097,870	30.00
31.00	03100 INTENSIVE CARE UNIT	0	691,486	31.00
43.00	04300 NURSERY	0	238,456	43.00
44.00	04400 SKILLED NURSING FACILITY	-761	644,712	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	-667,120	1,210,025	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	187,785	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,630	997,363	54.00
54.01	03630 ULTRA SOUND	0	0	54.01
56.00	05600 RADIOISOTOPE	0	135,133	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000 LABORATORY	0	1,368,789	60.00
65.00	06500 RESPIRATORY THERAPY	0	473,862	65.00
66.00	06600 PHYSICAL THERAPY	0	773,387	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	116,814	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	173,616	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	518,023	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	939,365	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.01	03951 SLEEP LAB	0	86,804	76.01
76.02	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.02
76.03	03953 WOUND CARE	0	34,002	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
90.00	09000 CLINIC	300	99,610	90.00
91.00	09100 EMERGENCY	-226,181	808,710	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00	SUBTOTALS (SUM OF LINES 1-117)	-6,870,547	31,903,945	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	43,936	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	-3,153	192.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTER	0	0	194.00
194.01	07955 MARKETING	-10,423	393,526	194.01
194.02	07952 SENIOR CIRCLE	0	5,517	194.02
194.03	07953 BUSINESS HEALTH	0	308,260	194.03
194.04	07954 VACANT SPACE	0	0	194.04
200.00	TOTAL (SUM OF LINES 118-199)	-6,880,970	32,652,031	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - EMPLOYEE BENEFITS</b>					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,283,233	1.00
	TOTALS		0	2,283,233	
<b>B - OXYGEN</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	7,143	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	7,143	
<b>C - RENTAL AND LEASE</b>					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	360,163	1.00
2.00	OPERATION OF PLANT	7.00	0	6,248	2.00
3.00	OCCUPATIONAL THERAPY	67.00	0	115	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
	TOTALS		0	366,526	
<b>D - OTHER CAPITAL COSTS</b>					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	56,076	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	12,275	2.00
3.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	397,122	3.00
	TOTALS		0	465,473	
<b>E - MARKETING</b>					
1.00	MARKETING	194.01	123,596	280,353	1.00
	TOTALS		123,596	280,353	
<b>F - CNO COST</b>					
1.00	NURSING ADMINISTRATION	13.00	117,761	0	1.00
	TOTALS		117,761	0	
<b>G - CHARGEABLE MEDICAL SUPPLIES</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	166,473	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	518,023	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	684,496	
<b>H - DRUGS AND IVS</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	939,365	1.00
	TOTALS		0	939,365	
<b>I - LABOR AND DELIVERY</b>					
1.00	NURSERY	43.00	187,631	50,825	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	147,760	40,025	2.00
	TOTALS		335,391	90,850	
<b>J - MISC DEPARTMENTS</b>					
1.00	OPERATING ROOM	50.00	303,788	755,871	1.00
2.00	CLINIC	90.00	43,346	13,557	2.00
3.00	PHYSICAL THERAPY	66.00	241,711	24,411	3.00
4.00	BUSINESS HEALTH	194.03	236,865	71,395	4.00
5.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	70,645	13,468	5.00
6.00	EMERGENCY	91.00	0	262,178	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
	TOTALS		896,355	1,140,880	
<b>K - RADIOLOGY</b>					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	372,397	58,933	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		372,397	58,933	

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet A-6  
Date/Time Prepared:  
2/26/2014 2:00 pm

		Increases			
Cost Center		Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
L - DIETARY					
1.00	CAFETERIA	11.00	334,359	219,203	1.00
	TOTALS		334,359	219,203	
M - FRAGMENTED A&G					
1.00	NONPATIENT TELEPHONES	5.01	80,623	230,781	1.00
2.00	ADMINISTRATIVE	5.02	350,017	50,873	2.00
3.00	CASHIERING/ACCOUNTS RECEIVABLE	5.03	259,250	4,107,327	3.00
	TOTALS		689,890	4,388,981	
500.00	Grand Total: Increases		2,869,749	10,925,436	500.00

RECLASSIFICATIONS

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet A-6  
Date/Time Prepared:  
2/26/2014 2:00 pm

		Decreases				Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
<b>A - EMPLOYEE BENEFITS</b>							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	2,283,233	0		1.00
	TOTALS		0	2,283,233			
<b>B - OXYGEN</b>							
1.00	OPERATION OF PLANT	7.00	0	41	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	7,102	0		2.00
	TOTALS		0	7,143			
<b>C - RENTAL AND LEASE</b>							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6,783	10		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	48,029	0		2.00
3.00	HOUSEKEEPING	9.00	0	16	0		3.00
4.00	DIETARY	10.00	0	2,482	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	11	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	7,977	0		6.00
7.00	PHARMACY	15.00	0	77,960	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	8,820	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	34,704	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	5,119	0		10.00
11.00	SKILLED NURSING FACILITY	44.00	0	7,294	0		11.00
12.00	OPERATING ROOM	50.00	0	2,297	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	74,538	0		13.00
14.00	LABORATORY	60.00	0	83,424	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	1,177	0		15.00
16.00	PHYSICAL THERAPY	66.00	0	2,794	0		16.00
17.00	SLEEP LAB	76.01	0	368	0		17.00
18.00	EMERGENCY	91.00	0	2,733	0		18.00
	TOTALS		0	366,526			
<b>D - OTHER CAPITAL COSTS</b>							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	465,473	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	13		3.00
	TOTALS		0	465,473			
<b>E - MARKETING</b>							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	123,596	280,353	0		1.00
	TOTALS		123,596	280,353			
<b>F - CNO COST</b>							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	117,761	0	0		1.00
	TOTALS		117,761	0			
<b>G - CHARGEABLE MEDICAL SUPPLIES</b>							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	654,806	0		1.00
2.00	OPERATING ROOM	50.00	0	29,569	0		2.00
3.00	RECOVERY ROOM	51.00	0	121	0		3.00
	TOTALS		0	684,496			
<b>H - DRUGS AND IVS</b>							
1.00	PHARMACY	15.00	0	939,365	0		1.00
	TOTALS		0	939,365			
<b>I - LABOR AND DELIVERY</b>							
1.00	ADULTS & PEDIATRICS	30.00	335,391	90,850	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		335,391	90,850			
<b>J - MISC DEPARTMENTS</b>							
1.00	RECOVERY ROOM	51.00	303,788	58,836	0		1.00
2.00	ANESTHESIOLOGY	53.00	0	697,034	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	43,346	13,557	0		3.00
4.00	OCCUPATIONAL THERAPY	67.00	175,305	18,044	0		4.00
5.00	SPEECH PATHOLOGY	68.00	66,406	6,367	0		5.00
6.00	LABORATORY	60.00	236,767	71,334	0		6.00
7.00	RURAL HEALTH CLINIC	88.00	98	62	0		7.00
8.00	NURSING ADMINISTRATION	13.00	70,645	13,468	0		8.00
9.00	AMBULANCE SERVICES	95.00	0	262,178	0		9.00
	TOTALS		896,355	1,140,880			
<b>K - RADIOLOGY</b>							
1.00	ULTRA SOUND	54.01	108,255	4,466	0		1.00
2.00	CT SCAN	57.00	158,852	36,090	0		2.00
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	105,290	18,377	0		3.00
	TOTALS		372,397	58,933			

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet A-6  
Date/Time Prepared:  
2/26/2014 2:00 pm

Decreases						Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
L - DIETARY							
1.00	DIETARY	10.00	334,359	219,203	0		1.00
	TOTALS		334,359	219,203			
M - FRAGMENTED A&G							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	689,890	4,388,981	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		689,890	4,388,981			
500.00	Grand Total: Decreases		2,869,749	10,925,436			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet A-7  
Part I  
Date/Time Prepared:  
2/26/2014 2:00 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	0	0	0	0	-3,844,900	1.00
2.00	Land Improvements	1,779,472	35	0	35	1,058,119	2.00
3.00	Buildings and Fixtures	60,744,074	1,440,342	0	1,440,342	28,775,967	3.00
4.00	Building Improvements	10,901,466	330,567	0	330,567	1,622,472	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	2,756,284	1,403,714	0	1,403,714	0	7.00
8.00	Subtotal (sum of lines 1-7)	76,181,296	3,174,658	0	3,174,658	27,611,658	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	76,181,296	3,174,658	0	3,174,658	27,611,658	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	3,844,900	0				1.00
2.00	Land Improvements	721,388	1,058,119				2.00
3.00	Buildings and Fixtures	33,408,449	24,853,067				3.00
4.00	Building Improvements	9,609,561	1,467,133				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	0	0				6.00
7.00	HIT designated Assets	4,159,998	0				7.00
8.00	Subtotal (sum of lines 1-7)	51,744,296	27,378,319				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	51,744,296	27,378,319				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet A-7  
Part II  
Date/Time Prepared:  
2/26/2014 2:00 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	NEW CAP REL COSTS-BLDG & FIXT	1,465,975	0	0	0	0	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,147,351	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,613,326	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,465,975				1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0				1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2,147,351				2.00
3.00	Total (sum of lines 1-2)	0	3,613,326				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet A-7  
Part III  
Date/Time Prepared:  
2/26/2014 2:00 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	NEW CAP REL COSTS-BLDG & FIXT	1,465,975	0	1,465,975	0.405713	0	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,147,351	0	2,147,351	0.594287	0	2.00
3.00	Total (sum of lines 1-2)	3,613,326	0	3,613,326	1.000000	0	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,065,295	0	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	0	145,796	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,428,421	360,163	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,639,512	360,163	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	310,186	56,076	397,122	0	1,828,679	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	0	0	145,796	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	103,380	12,275	0	0	1,904,239	2.00
3.00	Total (sum of lines 1-2)	413,566	68,351	397,122	0	3,878,714	3.00

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
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01 Investment income - WELLS CRC COSTS-BLDG & FIXT (chapter 2)			OWELLS CRC COSTS-BLDG & FIXT	1.01	0	1.01
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-990,418			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	B	-159	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-314,010			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-21,924	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employees 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	-346	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)	B	-3,490	NURSING ADMINISTRATION	13.00	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		RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		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 - NEW CAP REL COSTS-BLDG & FIXT	A	-400,680	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
26.01 Depreciation - WELLS CRC COSTS-BLDG & FIXT	A	145,796	WELLS CRC COSTS-BLDG & FIXT	1.01	9	26.01
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	A	-718,930	NEW 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

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center	Line #		
			1.00	2.00	3.00	
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	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 FITNESS REVENUE	B	-205,561		OTHER ADMINISTRATIVE AND GENERAL	5.04	0 33.00
34.00 MISC REVENUE	B	-1,881		OTHER ADMINISTRATIVE AND GENERAL	5.04	0 34.00
35.00 BAD DEBT	A	-3,500,498		CASHIERING/ACCOUNTS RECEIVABLE	5.03	0 35.00
36.00 LOST CHARGES	A	-30		OPERATING ROOM	50.00	0 36.00
37.00 PHYSICIAN RECRUITING	A	-25,185		OTHER ADMINISTRATIVE AND GENERAL	5.04	0 37.00
38.00 LOBBYING IN ASSOCIATION DUES	A	-2,166		OTHER ADMINISTRATIVE AND GENERAL	5.04	0 38.00
40.00 CHARITABLE CONTRIBUTIONS	A	-17,760		OTHER ADMINISTRATIVE AND GENERAL	5.04	0 40.00
41.00 LOBBYING EXPENSE	A	-1,183		OTHER ADMINISTRATIVE AND GENERAL	5.04	0 41.00
42.00 PENALTIES	A	-25		OTHER ADMINISTRATIVE AND GENERAL	5.04	0 42.00
43.00 CRNA	A	-667,034		OPERATING ROOM	50.00	0 43.00
44.00 PATIENT PHONE WAGES	A	-20,637		NONPATIENT TELEPHONES	5.01	0 44.00
45.00 PATIENT PHONE BENEFITS	A	-5,076		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 45.00
45.01 PATIENT PHONE SERVICE EXPENSE	A	-31,519		NONPATIENT TELEPHONES	5.01	0 45.01
45.02		0			0.00	0 45.02
45.03 PATIENT TV EXPENSE	A	-13,649		OTHER ADMINISTRATIVE AND GENERAL	5.04	0 45.03
45.04 MARKETING	A	-56,503		OTHER ADMINISTRATIVE AND GENERAL	5.04	0 45.04
45.06 SPECIAL EVENTS	A	-184		OTHER ADMINISTRATIVE AND GENERAL	5.04	0 45.06
45.07 MEDICAL STAFF AND BOARD RELATIONS	A	-1,989		OTHER ADMINISTRATIVE AND GENERAL	5.04	0 45.07
45.08 LEGAL FEES	A	-23,302		OTHER ADMINISTRATIVE AND GENERAL	5.04	0 45.08
45.09 COUNTRY CLUB DUES	A	-2,627		OTHER ADMINISTRATIVE AND GENERAL	5.04	0 45.09
45.10		0			0.00	0 45.10
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,880,970				50.00

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

Provider CCN: 150075

Period: From 10/01/2012 To 09/30/2013

Worksheet A-8-1

Date/Time Prepared: 2/26/2014 2:00 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	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAI MED HOME OFFICE COSTS:</b>					
1.00	5.04	OTHER ADMINISTRATIVE AND GEN MANAGEMENT FEES	0	884,500	1.00
2.00	5.04	OTHER ADMINISTRATIVE AND GEN 401K FEES	0	1,243	2.00
3.00	5.04	OTHER ADMINISTRATIVE AND GEN AUDIT FEES	0	24,312	3.00
4.00	5.04	OTHER ADMINISTRATIVE AND GEN MIS FEES	0	217,717	4.00
4.01	5.04	OTHER ADMINISTRATIVE AND GEN MANAGED CARE FEES	0	15,552	4.01
4.02	5.04	OTHER ADMINISTRATIVE AND GEN CASE MANAGEMENT FEES	0	60,956	4.02
4.03	5.04	OTHER ADMINISTRATIVE AND GEN PURCHASE & ANCILLARY FEES	0	4,639	4.03
4.04	5.04	OTHER ADMINISTRATIVE AND GEN ER	0	32,542	4.04
4.05	5.04	OTHER ADMINISTRATIVE AND GEN PPSI FEES	0	18,323	4.05
4.06	5.04	OTHER ADMINISTRATIVE AND GEN COMPLIANCE/HIM/CCA FEES	0	18,329	4.06
4.07	194.01	MARKETING SENIOR CIRCLE	0	10,423	4.07
4.08	5.03	CASHIERING/ACCOUNTS RECEIVAB PASI OPERATING	98,477	153,789	4.08
4.09	1.00	NEW CAP REL COSTS-BLDG & FIX PASI CAPITAL	5,493	0	4.09
4.10	2.00	NEW CAP REL COSTS-MVBLE EQUI PASI CAPITAL	2,742	0	4.10
4.11	5.04	OTHER ADMINISTRATIVE AND GEN PASI CALL CENTER	0	8,971	4.11
4.12	5.03	CASHIERING/ACCOUNTS RECEIVAB PASI LIEN UNIT	0	7,797	4.12
4.13	1.00	NEW CAP REL COSTS-BLDG & FIX DIRECT INTEREST	287,308	0	4.13
4.14	1.00	NEW CAP REL COSTS-BLDG & FIX POOLED CAPITAL - BLDG	17,385	0	4.14
4.15	2.00	NEW CAP REL COSTS-MVBLE EQUI POOLED CAPITAL - FF&E	100,638	0	4.15
4.16	5.04	OTHER ADMINISTRATIVE AND GEN POOLED HOME OFFICE COSTS	827,659	0	4.16
4.17	8.00	LAUNDRY & LINEN SERVICE LAUNDRY SERVICE	136,998	164,698	4.17
4.18	5.04	OTHER ADMINISTRATIVE AND GEN MALPRACTICE	191,827	359,018	4.18
4.19	5.04	OTHER ADMINISTRATIVE AND GEN CONVERSION COSTS	272	0	4.19
5.00	0		1,668,799	1,982,809	5.00

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

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

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

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

6.00	B		0.00	CHS, INC.	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet A-8-1

Date/Time Prepared:  
2/26/2014 2:00 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	-884,500	0		1.00
2.00	-1,243	0		2.00
3.00	-24,312	0		3.00
4.00	-217,717	0		4.00
4.01	-15,552	0		4.01
4.02	-60,956	0		4.02
4.03	-4,639	0		4.03
4.04	-32,542	0		4.04
4.05	-18,323	0		4.05
4.06	-18,329	0		4.06
4.07	-10,423	0		4.07
4.08	-55,312	0		4.08
4.09	5,493	11		4.09
4.10	2,742	11		4.10
4.11	-8,971	0		4.11
4.12	-7,797	0		4.12
4.13	287,308	11		4.13
4.14	17,385	11		4.14
4.15	100,638	11		4.15
4.16	827,659	0		4.16
4.17	-27,700	0		4.17
4.18	-167,191	0		4.18
4.19	272	0		4.19
5.00	-314,010			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	HEALTHCARE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet A-8-2  
Date/Time Prepared:  
2/26/2014 2:00 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.04	OTHER ADMINISTRATIVE AND GENERAL	28,511	28,511	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	45,265	390	44,875	142,500	300	2.00
3.00	15.00	PHARMACY	600	600	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	715,686	715,686	0	0	0	4.00
5.00	44.00	SKILLED NURSING FACILITY	761	761	0	0	0	5.00
6.00	50.00	OPERATING ROOM	56	56	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	-5,789	-5,789	0	0	0	7.00
8.00	90.00	CLINIC	-300	-300	0	0	0	8.00
9.00	91.00	EMERGENCY	226,181	226,181	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,010,971	966,096	44,875		300	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.04	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	20,553	1,028	0	0	0	2.00
3.00	15.00	PHARMACY	0	0	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	44.00	SKILLED NURSING FACILITY	0	0	0	0	0	5.00
6.00	50.00	OPERATING ROOM	0	0	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	7.00
8.00	90.00	CLINIC	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			20,553	1,028	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.04	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	28,511		1.00
2.00	13.00	NURSING ADMINISTRATION	0	20,553	24,322	24,712		2.00
3.00	15.00	PHARMACY	0	0	0	600		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	715,686		4.00
5.00	44.00	SKILLED NURSING FACILITY	0	0	0	761		5.00
6.00	50.00	OPERATING ROOM	0	0	0	56		6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	-5,789		7.00
8.00	90.00	CLINIC	0	0	0	-300		8.00
9.00	91.00	EMERGENCY	0	0	0	226,181		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	20,553	24,322	990,418		200.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet B Part I Date/Time Prepared: 2/26/2014 2:00 pm
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	WELLS CRC COSTS-BLDG & FIXT	NEW MVBLE EQUIP		
	0	1.00	1.01	2.00	4.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	1,828,679	1,828,679			1.00
1.01 00101	WELLS CRC COSTS-BLDG & FIXT	145,796	0	145,796		1.01
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	1,904,239			1,904,239	2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,540,277		1,866	13,893	2,556,036
5.01 00510	NONPATIENT TELEPHONES	259,248	9,162	0	8,918	15,906
5.02 00540	ADMITTING	400,890	12,145	0	0	69,056
5.03 00550	CASHIERING/ACCOUNTS RECEIVABLE	802,970	17,888	0	0	51,148
5.04 00560	OTHER ADMINISTRATIVE AND GENERAL	6,116,800	150,798	933	18,768	246,257
7.00 00700	OPERATION OF PLANT	2,144,355	105,785	0	102,968	98,158
8.00 00800	LAUNDRY & LINEN SERVICE	136,998	1,784	3,329	26,520	0
9.00 00900	HOUSEKEEPING	492,373	7,536	0	7,335	56,441
10.00 01000	DIETARY	181,554	74,033	0	72,061	21,635
11.00 01100	CAFETERIA	531,638	0	4,287	31,911	65,967
13.00 01300	NURSING ADMINISTRATION	1,142,239	3,717	0	3,618	186,850
14.00 01400	CENTRAL SERVICES & SUPPLY	515,069	91,791	0	89,346	26,176
15.00 01500	PHARMACY	593,853	0	0	0	97,593
16.00 01600	MEDICAL RECORDS & LIBRARY	571,155	21,819	0	21,238	78,045
17.00 01700	SOCIAL SERVICE	0	3,559	0	3,464	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	2,097,870	155,007	0	150,879	330,095
31.00 03100	INTENSIVE CARE UNIT	691,486	27,310	0	26,583	118,781
43.00 04300	NURSERY	238,456	4,544	0	4,423	37,018
44.00 04400	SKILLED NURSING FACILITY	644,712	55,448	0	53,971	107,830
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	1,210,025	145,882	0	141,997	165,588
51.00 05100	RECOVERY ROOM	0	0	0	0	0
52.00 05200	DELIVERY ROOM & LABOR ROOM	187,785	5,352	0	5,210	29,152
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	997,363	101,557	0	98,853	166,565
54.01 03630	ULTRA SOUND	0	0	0	0	0
56.00 05600	RADIOISOTOPE	135,133	6,616	0	6,440	12,787
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
60.00 06000	LABORATORY	1,368,789	42,058	0	40,938	130,253
65.00 06500	RESPIRATORY THERAPY	473,862	49,334	0	48,020	79,910
66.00 06600	PHYSICAL THERAPY	773,387	45,784	0	44,565	131,163
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00 06900	ELECTROCARDIOLOGY	116,814	0	1,575	11,722	7,823
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	173,616	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	518,023	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	939,365	13,613	1,780	26,502	0
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.01 03951	SLEEP LAB	86,804	3,224	0	3,139	14,805
76.02 03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.03 03953	WOUND CARE	34,002	0	0	0	3,079
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0
90.00 09000	CLINIC	99,610	9,980	0	9,714	14,704
91.00 09100	EMERGENCY	808,710	44,213	0	43,036	120,075
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	31,903,945	1,209,939	13,770	1,116,032	2,482,860
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	43,936	8,577	0	8,349	1,843
192.00 19200	PHYSICIANS' PRIVATE OFFICES	-3,153	556,935	19,838	689,789	0
194.00 07950	OTHER NONREIMBURSABLE COST CENTER	0	32,905	0	32,028	0
194.01 07955	MARKETING	393,526	20,323	0	19,781	24,385
194.02 07952	SENIOR CIRCLE	5,517	0	0	5,017	216
194.03 07953	BUSINESS HEALTH	308,260	0	5,139	38,260	46,732
194.04 07954	VACANT SPACE	0	0	107,049	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	32,652,031	1,828,679	145,796	1,904,239	2,556,036

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet B  
Part I  
Date/Time Prepared:  
2/26/2014 2:00 pm

Cost Center Description		NONPATIENT TELEPHONES	Subtotal	ADMITTING	Subtotal	CASHIERING/AC COUNTS RECEIVABLE	
		5.01	5A.01	5.02	5A.02	5.03	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.01	00510	293,234					5.01
5.02	00540	4,757	486,848	486,848			5.02
5.03	00550	3,460	875,466	13,251	888,717	888,717	5.03
5.04	00560	22,490	6,556,046	99,227	6,655,273	186,218	5.04
7.00	00700	5,190	2,456,456	37,181	2,493,637	69,769	7.00
8.00	00800	432	169,063	2,559	171,622	4,802	8.00
9.00	00900	865	564,550	8,545	573,095	16,035	9.00
10.00	01000	3,892	353,175	5,346	358,521	10,031	10.00
11.00	01100	0	633,803	9,593	643,396	18,002	11.00
13.00	01300	1,297	1,337,721	20,248	1,357,969	37,995	13.00
14.00	01400	2,162	724,544	10,967	735,511	20,579	14.00
15.00	01500	4,757	696,203	10,538	706,741	19,774	15.00
16.00	01600	10,812	703,069	10,642	713,711	19,969	16.00
17.00	01700	865	7,888	119	8,007	224	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	8,650	2,742,501	41,510	2,784,011	77,894	30.00
31.00	03100	2,162	866,322	13,113	879,435	24,606	31.00
43.00	04300	432	284,873	4,312	289,185	8,091	43.00
44.00	04400	4,325	866,286	13,112	879,398	24,605	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	14,705	1,678,197	25,401	1,703,598	47,665	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	865	228,364	3,457	231,821	6,486	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	9,082	1,373,420	20,788	1,394,208	39,009	54.00
54.01	03630	0	0	0	0	0	54.01
56.00	05600	865	161,841	2,450	164,291	4,597	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	8,217	1,590,255	24,070	1,614,325	45,167	60.00
65.00	06500	1,297	652,423	9,875	662,298	18,530	65.00
66.00	06600	2,162	997,061	15,092	1,012,153	28,319	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	2,595	140,529	2,127	142,656	3,991	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	173,616	2,628	176,244	4,931	71.00
72.00	07200	0	518,023	7,841	525,864	14,713	72.00
73.00	07300	0	981,260	14,852	996,112	27,870	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	0	107,972	1,634	109,606	3,067	76.01
76.02	03952	0	0	0	0	0	76.02
76.03	03953	0	37,081	561	37,642	1,053	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
90.00	09000	2,162	136,170	2,061	138,231	3,868	90.00
91.00	09100	7,352	1,023,386	15,490	1,038,876	29,067	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		125,850	30,124,412	448,590	30,086,154	816,927	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	1,730	64,435	975	65,410	1,830	190.00
192.00	19200	164,789	1,428,198	21,617	1,449,815	40,564	192.00
194.00	07950	865	65,798	996	66,794	1,869	194.00
194.01	07955	0	458,015	6,933	464,948	13,009	194.01
194.02	07952	0	5,733	87	5,820	163	194.02
194.03	07953	0	398,391	6,030	404,421	11,315	194.03
194.04	07954	0	107,049	1,620	108,669	3,040	194.04
200.00			0		0		200.00
201.00		0	0	0	0	0	201.00
202.00		293,234	32,652,031	486,848	32,652,031	888,717	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet B Part I Date/Time Prepared: 2/26/2014 2:00 pm			
Cost Center	Description	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.04	7.00	8.00	9.00	10.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	WELLS CRC COSTS-BLDG & FIXT					1.01	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	00510	NONPATIENT TELEPHONES					5.01	
5.02	00540	ADMITTING					5.02	
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE					5.03	
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	6,841,491				5.04	
7.00	00700	OPERATION OF PLANT	0	2,563,406			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	38,632	215,056		8.00	
9.00	00900	HOUSEKEEPING	0	10,686	0	599,816	9.00	
10.00	01000	DIETARY	0	104,974	0	25,045	10.00	
11.00	01100	CAFETERIA	0	46,485	0	11,091	11.00	
13.00	01300	NURSING ADMINISTRATION	0	5,270	0	1,257	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	130,154	0	31,052	14.00	
15.00	01500	PHARMACY	0	0	0	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	30,938	0	7,381	16.00	
17.00	01700	SOCIAL SERVICE	0	5,046	0	1,204	17.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	536,949	219,791	89,981	52,438	289,981	30.00
31.00	03100	INTENSIVE CARE UNIT	117,165	38,725	12,437	9,239	32,050	31.00
43.00	04300	NURSERY	28,256	6,443	0	1,537	0	43.00
44.00	04400	SKILLED NURSING FACILITY	117,707	78,622	27,002	18,758	176,540	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,050,180	206,852	35,703	49,351	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	22,251	7,589	21,103	1,811	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,260,466	144,002	16	34,356	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	41,067	9,381	0	2,238	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,466,532	59,635	0	14,228	0	60.00
65.00	06500	RESPIRATORY THERAPY	237,808	69,952	0	16,689	0	65.00
66.00	06600	PHYSICAL THERAPY	228,086	64,919	0	15,488	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	121,224	17,076	0	4,074	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	274,660	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	174,686	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	482,683	38,606	0	9,211	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	54,604	4,572	175	1,091	0	76.01
76.02	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.02
76.03	03953	WOUND CARE	5,216	0	19	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	22,666	14,151	0	3,376	0	90.00
91.00	09100	EMERGENCY	599,285	62,692	27,130	14,957	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,841,491	1,415,193	213,566	325,872	498,571	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,162	0	2,902	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,004,843	0	239,739	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	46,657	0	11,131	0	194.00
194.01	07955	MARKETING	0	28,816	0	6,875	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	BUSINESS HEALTH	0	55,735	1,490	13,297	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	6,841,491	2,563,406	215,056	599,816	498,571	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet B  
Part I  
Date/Time Prepared:  
2/26/2014 2:00 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00540						5.02
5.03	00550						5.03
5.04	00560						5.04
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	718,974					11.00
13.00	01300	50,469	1,452,960				13.00
14.00	01400	10,882	0	928,178			14.00
15.00	01500	26,816	0	26,517	779,848		15.00
16.00	01600	42,174	0	1,704	0	815,877	16.00
17.00	01700	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	147,222	600,169	89,278	0	64,034	30.00
31.00	03100	39,710	161,886	14,871	0	13,972	31.00
43.00	04300	12,730	51,897	0	0	3,370	43.00
44.00	04400	48,827	199,052	12,441	0	14,037	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	51,373	209,431	72,783	0	125,239	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	10,020	40,848	0	0	2,654	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	56,054	0	21,626	0	150,316	54.00
54.01	03630	0	0	0	0	0	54.01
56.00	05600	3,408	0	21,191	0	4,897	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	63,118	0	216,720	0	174,888	60.00
65.00	06500	27,103	0	7,430	0	28,360	65.00
66.00	06600	43,570	0	19,427	0	27,200	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	2,834	0	0	0	14,457	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	120,898	0	32,754	71.00
72.00	07200	0	0	225,597	0	20,832	72.00
73.00	07300	0	0	0	779,848	57,562	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	5,339	0	2,402	0	6,512	76.01
76.02	03952	0	0	0	0	0	76.02
76.03	03953	1,684	6,864	7,147	0	622	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
90.00	09000	4,065	0	7,523	0	2,703	90.00
91.00	09100	44,843	182,813	36,697	0	71,468	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		692,241	1,452,960	904,252	779,848	815,877	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	1,027	0	13,516	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07955	7,186	0	581	0	0	194.01
194.02	07952	123	0	45	0	0	194.02
194.03	07953	18,397	0	9,784	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		718,974	1,452,960	928,178	779,848	815,877	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet B  
Part I  
Date/Time Prepared:  
2/26/2014 2:00 pm

Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00510	NONPATIENT TELEPHONES				5.01
5.02	00540	ADMINISTRATIVE				5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE				5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL				5.04
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	14,481			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	5,220	4,956,968	0	4,956,968
31.00	03100	INTENSIVE CARE UNIT	5,947	1,350,043	0	1,350,043
43.00	04300	NURSERY	457	401,966	0	401,966
44.00	04400	SKILLED NURSING FACILITY	2,857	1,599,846	0	1,599,846
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	0	3,552,175	0	3,552,175
51.00	05100	RECOVERY ROOM	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	344,583	0	344,583
53.00	05300	ANESTHESIOLOGY	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,100,053	0	3,100,053
54.01	03630	ULTRASOUND	0	0	0	0
56.00	05600	RADIOISOTOPE	0	251,070	0	251,070
57.00	05700	CT SCAN	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0
60.00	06000	LABORATORY	0	3,654,613	0	3,654,613
65.00	06500	RESPIRATORY THERAPY	0	1,068,170	0	1,068,170
66.00	06600	PHYSICAL THERAPY	0	1,439,162	0	1,439,162
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	306,312	0	306,312
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	609,487	0	609,487
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	961,692	0	961,692
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,391,892	0	2,391,892
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0
76.01	03951	SLEEP LAB	0	187,368	0	187,368
76.02	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0
76.03	03953	WOUND CARE	0	60,247	0	60,247
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0
90.00	09000	CLINIC	0	196,583	0	196,583
91.00	09100	EMERGENCY	0	2,107,828	0	2,107,828
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	AMBULANCE SERVICES	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,481	28,540,058	0	28,540,058
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	96,847	0	96,847
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,734,961	0	2,734,961
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	126,451	0	126,451
194.01	07955	MARKETING	0	521,415	0	521,415
194.02	07952	SENIOR CIRCLE	0	6,151	0	6,151
194.03	07953	BUSINESS HEALTH	0	514,439	0	514,439
194.04	07954	VACANT SPACE	0	111,709	0	111,709
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)	14,481	32,652,031	0	32,652,031

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet B Part II Date/Time Prepared: 2/26/2014 2:00 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
		NEW BLDG & FIXT	WELLS CRC COSTS-BLDG & FIXT	NEW MVBLE EQUIP		
		0	1.00	1.01		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	1,866	13,893
5.01	00510	NONPATIENT TELEPHONES	0	9,162	0	8,918
5.02	00540	ADMINITTING	0	12,145	0	0
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	17,888	0	0
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	0	150,798	933	18,768
7.00	00700	OPERATION OF PLANT	0	105,785	0	102,968
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,784	3,329	26,520
9.00	00900	HOUSEKEEPING	0	7,536	0	7,335
10.00	01000	DIETARY	0	74,033	0	72,061
11.00	01100	CAFETERIA	0	0	4,287	31,911
13.00	01300	NURSING ADMINISTRATION	0	3,717	0	3,618
14.00	01400	CENTRAL SERVICES & SUPPLY	0	91,791	0	89,346
15.00	01500	PHARMACY	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	21,819	0	21,238
17.00	01700	SOCIAL SERVICE	0	3,559	0	3,464
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	0	155,007	0	150,879
31.00	03100	INTENSIVE CARE UNIT	0	27,310	0	26,583
43.00	04300	NURSERY	0	4,544	0	4,423
44.00	04400	SKILLED NURSING FACILITY	0	55,448	0	53,971
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	0	145,882	0	141,997
51.00	05100	RECOVERY ROOM	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,352	0	5,210
53.00	05300	ANESTHESIOLOGY	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	101,557	0	98,853
54.01	03630	ULTRA SOUND	0	0	0	0
56.00	05600	RADIOISOTOPE	0	6,616	0	6,440
57.00	05700	CT SCAN	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0
60.00	06000	LABORATORY	0	42,058	0	40,938
65.00	06500	RESPIRATORY THERAPY	0	49,334	0	48,020
66.00	06600	PHYSICAL THERAPY	0	45,784	0	44,565
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	1,575	11,722
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,613	1,780	26,502
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0
76.01	03951	SLEEP LAB	0	3,224	0	3,139
76.02	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0
76.03	03953	WOUND CARE	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0
90.00	09000	CLINIC	0	9,980	0	9,714
91.00	09100	EMERGENCY	0	44,213	0	43,036
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	AMBULANCE SERVICES	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,209,939	13,770	1,116,032
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,577	0	8,349
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	556,935	19,838	689,789
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	32,905	0	32,028
194.01	07955	MARKETING	0	20,323	0	19,781
194.02	07952	SENIOR CIRCLE	0	0	0	0
194.03	07953	BUSINESS HEALTH	0	0	5,139	38,260
194.04	07954	VACANT SPACE	0	0	107,049	0
200.00		Cross Foot Adjustments				0
201.00		Negative Cost Centers		0	0	0
202.00		TOTAL (sum lines 118-201)	0	1,828,679	145,796	1,904,239

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet B Part II Date/Time Prepared: 2/26/2014 2:00 pm			
Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	ADMINISTRATIVE	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	
			4.00	5.01	5.02	5.03	5.04	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	15,759					4.00
5.01	00510	NONPATIENT TELEPHONES	98	18,178				5.01
5.02	00540	ADMINISTRATIVE	426	295	12,866			5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	315	214	350	18,767		5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	1,518	1,394	2,624	3,927	179,962	5.04
7.00	00700	OPERATION OF PLANT	605	322	983	1,474	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	27	68	101	0	8.00
9.00	00900	HOUSEKEEPING	348	54	226	339	0	9.00
10.00	01000	DIETARY	133	241	141	212	0	10.00
11.00	01100	CAFETERIA	407	0	254	380	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,152	80	535	803	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	161	134	290	435	0	14.00
15.00	01500	PHARMACY	602	295	278	418	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	481	670	281	422	0	16.00
17.00	01700	SOCIAL SERVICE	0	54	3	5	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	2,038	536	1,097	1,645	14,121	30.00
31.00	03100	INTENSIVE CARE UNIT	732	134	347	520	3,081	31.00
43.00	04300	NURSERY	228	27	114	171	743	43.00
44.00	04400	SKILLED NURSING FACILITY	665	268	347	520	3,096	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,021	912	671	1,007	27,618	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	180	54	91	137	585	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,027	563	549	824	33,148	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	79	54	65	97	1,080	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	803	509	636	954	38,610	60.00
65.00	06500	RESPIRATORY THERAPY	493	80	261	391	6,254	65.00
66.00	06600	PHYSICAL THERAPY	808	134	399	598	5,998	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	48	161	56	84	3,188	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	69	104	7,223	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	207	311	4,594	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	393	589	12,694	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	91	0	43	65	1,436	76.01
76.02	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.02
76.03	03953	WOUND CARE	19	0	15	22	137	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	91	134	54	82	596	90.00
91.00	09100	EMERGENCY	740	456	409	614	15,760	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,309	7,802	11,856	17,251	179,962	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11	107	26	39	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,215	571	857	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	54	26	39	0	194.00
194.01	07955	MARKETING	150	0	183	275	0	194.01
194.02	07952	SENIOR CIRCLE	1	0	2	3	0	194.02
194.03	07953	BUSINESS HEALTH	288	0	159	239	0	194.03
194.04	07954	VACANT SPACE	0	0	43	64	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	15,759	18,178	12,866	18,767	179,962	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet B Part II Date/Time Prepared: 2/26/2014 2:00 pm
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Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	NONPATIENT TELEPHONES					5.01
5.02	00540	ADMITTING					5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL					5.04
7.00	00700	OPERATION OF PLANT	212,137				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,197	35,026			8.00
9.00	00900	HOUSEKEEPING	884	0	16,722		9.00
10.00	01000	DIETARY	8,687	0	698	156,206	10.00
11.00	01100	CAFETERIA	3,847	0	309	0	41,395
13.00	01300	NURSING ADMINISTRATION	436	0	35	0	2,906
14.00	01400	CENTRAL SERVICES & SUPPLY	10,771	0	866	0	627
15.00	01500	PHARMACY	0	0	0	0	1,544
16.00	01600	MEDICAL RECORDS & LIBRARY	2,560	0	206	0	2,428
17.00	01700	SOCIAL SERVICE	418	0	34	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	18,189	14,654	1,462	90,854	8,477
31.00	03100	INTENSIVE CARE UNIT	3,205	2,026	258	10,041	2,286
43.00	04300	NURSERY	533	0	43	0	733
44.00	04400	SKILLED NURSING FACILITY	6,506	4,398	523	55,311	2,811
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	17,118	5,815	1,376	0	2,958
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	628	3,437	50	0	577
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,917	3	958	0	3,227
54.01	03630	ULTRA SOUND	0	0	0	0	0
56.00	05600	RADIOISOTOPE	776	0	62	0	196
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
60.00	06000	LABORATORY	4,935	0	397	0	3,634
65.00	06500	RESPIRATORY THERAPY	5,789	0	465	0	1,560
66.00	06600	PHYSICAL THERAPY	5,372	0	432	0	2,509
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	1,413	0	114	0	163
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	3,195	0	257	0	0
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.01	03951	SLEEP LAB	378	28	30	0	307
76.02	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.03	03953	WOUND CARE	0	3	0	0	97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
90.00	09000	CLINIC	1,171	0	94	0	234
91.00	09100	EMERGENCY	5,188	4,419	417	0	2,582
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	117,113	34,783	9,086	156,206	39,856
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,006	0	81	0	59
192.00	19200	PHYSICIANS' PRIVATE OFFICES	83,160	0	6,682	0	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	3,861	0	310	0	0
194.01	07955	MARKETING	2,385	0	192	0	414
194.02	07952	SENIOR CIRCLE	0	0	0	0	7
194.03	07953	BUSINESS HEALTH	4,612	243	371	0	1,059
194.04	07954	VACANT SPACE	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	212,137	35,026	16,722	156,206	41,395

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet B Part II Date/Time Prepared: 2/26/2014 2:00 pm
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Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00540						5.02
5.03	00550						5.03
5.04	00560						5.04
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	13,282					13.00
14.00	01400	0	194,421				14.00
15.00	01500	0	5,554	8,691			15.00
16.00	01600	0	357	0	50,462		16.00
17.00	01700	0	0	0	0	7,537	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	5,487	18,701	0	3,956	2,717	30.00
31.00	03100	1,480	3,115	0	863	3,095	31.00
43.00	04300	474	0	0	208	238	43.00
44.00	04400	1,820	2,606	0	867	1,487	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	1,914	15,245	0	7,736	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	373	0	0	164	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	4,530	0	9,286	0	54.00
54.01	03630	0	0	0	0	0	54.01
56.00	05600	0	4,439	0	303	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	0	45,395	0	10,866	0	60.00
65.00	06500	0	1,556	0	1,752	0	65.00
66.00	06600	0	4,069	0	1,680	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	893	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	25,324	0	2,023	0	71.00
72.00	07200	0	47,256	0	1,287	0	72.00
73.00	07300	0	0	8,691	3,556	0	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	0	503	0	402	0	76.01
76.02	03952	0	0	0	0	0	76.02
76.03	03953	63	1,497	0	38	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
90.00	09000	0	1,576	0	167	0	90.00
91.00	09100	1,671	7,687	0	4,415	0	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		13,282	189,410	8,691	50,462	7,537	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	2,831	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07955	0	122	0	0	0	194.01
194.02	07952	0	9	0	0	0	194.02
194.03	07953	0	2,049	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		13,282	194,421	8,691	50,462	7,537	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet B Part II Date/Time Prepared: 2/26/2014 2:00 pm
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
1.01	00101				1.01
2.00	00200				2.00
4.00	00400				4.00
5.01	00510				5.01
5.02	00540				5.02
5.03	00550				5.03
5.04	00560				5.04
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
17.00	01700				17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	489,820	0	489,820	30.00
31.00	03100	85,076	0	85,076	31.00
43.00	04300	12,479	0	12,479	43.00
44.00	04400	190,644	0	190,644	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	371,270	0	371,270	50.00
51.00	05100	0	0	0	51.00
52.00	05200	16,838	0	16,838	52.00
53.00	05300	0	0	0	53.00
54.00	05400	266,442	0	266,442	54.00
54.01	03630	0	0	0	54.01
56.00	05600	20,207	0	20,207	56.00
57.00	05700	0	0	0	57.00
58.00	05800	0	0	0	58.00
60.00	06000	189,735	0	189,735	60.00
65.00	06500	115,955	0	115,955	65.00
66.00	06600	112,348	0	112,348	66.00
67.00	06700	0	0	0	67.00
68.00	06800	0	0	0	68.00
69.00	06900	19,417	0	19,417	69.00
70.00	07000	0	0	0	70.00
71.00	07100	34,743	0	34,743	71.00
72.00	07200	53,655	0	53,655	72.00
73.00	07300	71,270	0	71,270	73.00
76.00	03950	0	0	0	76.00
76.01	03951	9,646	0	9,646	76.01
76.02	03952	0	0	0	76.02
76.03	03953	1,891	0	1,891	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	0	0	0	88.00
90.00	09000	23,893	0	23,893	90.00
91.00	09100	131,607	0	131,607	91.00
92.00	09200	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	0	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		2,216,936	0	2,216,936	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	21,086	0	21,086	190.00
192.00	19200	1,368,047	0	1,368,047	192.00
194.00	07950	69,223	0	69,223	194.00
194.01	07955	43,825	0	43,825	194.01
194.02	07952	22	0	22	194.02
194.03	07953	52,419	0	52,419	194.03
194.04	07954	107,156	0	107,156	194.04
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		3,878,714	0	3,878,714	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet B-1  
Date/Time Prepared:  
2/26/2014 2:00 pm

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF TELEPHONES)	
		NEW BLDG & FIXT (SQUARE FEET)	WELLS CRC COSTS-BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)			
		1.00	1.01	2.00	4.00	5.01	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	196,792				1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT	0	119,997			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			210,530		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		1,536	1,536	12,955,509	4.00
5.01	00510	NONPATIENT TELEPHONES	986	0	986	80,623	678 5.01
5.02	00540	ADMITTING	1,307	0	0	350,017	11 5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	1,925	0	0	259,250	8 5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	16,228	768	2,075	1,248,180	52 5.04
7.00	00700	OPERATION OF PLANT	11,384	0	11,384	497,526	12 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	192	2,740	2,932	0	1 8.00
9.00	00900	HOUSEKEEPING	811	0	811	286,075	2 9.00
10.00	01000	DIETARY	7,967	0	7,967	109,661	9 10.00
11.00	01100	CAFETERIA	0	3,528	3,528	334,359	0 11.00
13.00	01300	NURSING ADMINISTRATION	400	0	400	947,071	3 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,878	0	9,878	132,675	5 14.00
15.00	01500	PHARMACY	0	0	0	494,661	11 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,348	0	2,348	395,578	25 16.00
17.00	01700	SOCIAL SERVICE	383	0	383	0	2 17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	16,681	0	16,681	1,673,085	20 30.00
31.00	03100	INTENSIVE CARE UNIT	2,939	0	2,939	602,055	5 31.00
43.00	04300	NURSERY	489	0	489	187,631	1 43.00
44.00	04400	SKILLED NURSING FACILITY	5,967	0	5,967	546,546	10 44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	15,699	0	15,699	839,302	34 50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	576	0	576	147,760	2 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,929	0	10,929	844,252	21 54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0 54.01
56.00	05600	RADIOISOTOPE	712	0	712	64,814	2 56.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
60.00	06000	LABORATORY	4,526	0	4,526	660,200	19 60.00
65.00	06500	RESPIRATORY THERAPY	5,309	0	5,309	405,033	3 65.00
66.00	06600	PHYSICAL THERAPY	4,927	0	4,927	664,814	5 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	1,296	1,296	39,653	6 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,465	1,465	2,930	0	0 73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0 76.00
76.01	03951	SLEEP LAB	347	0	347	75,042	0 76.01
76.02	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0 76.02
76.03	03953	WOUND CARE	0	0	0	15,606	0 76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
90.00	09000	CLINIC	1,074	0	1,074	74,528	5 90.00
91.00	09100	EMERGENCY	4,758	0	4,758	608,615	17 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	130,207	11,333	123,387	12,584,612	291 118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	923	0	923	9,343	4 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	59,934	16,328	76,262	0	381 192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	3,541	0	3,541	0	2 194.00
194.01	07955	MARKETING	2,187	0	2,187	123,596	0 194.01
194.02	07952	SENIOR CIRCLE	0	0	0	1,093	0 194.02
194.03	07953	BUSINESS HEALTH	0	4,230	4,230	236,865	0 194.03
194.04	07954	VACANT SPACE	0	88,106	0	0	0 194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,828,679	145,796	1,904,239	2,556,036	293,234 202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet B-1  
Date/Time Prepared:  
2/26/2014 2:00 pm

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF TELEPHONES)	
		NEW BLDG & FIXT (SQUARE FEET)	WELLS CRC COSTS-BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)			
		1.00	1.01	2.00			
203.00	Unit cost multiplier (Wkst. B, Part I)	9.292446	1.214997	9.044977	0.197293	432.498525	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)				15,759	18,178	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)				0.001216	26.811209	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet B-1

Date/Time Prepared:  
2/26/2014 2:00 pm

Cost Center Description			Reconciliation	ADMITTING (ACCUM. COST)	Reconciliation	CASHIERING/ACCOUNTS RECEIVABLE (ACCUM. COST)	OTHER ADMINISTRATIVE AND GENERAL (GROSS CHARGES)	
			5A.02	5.02	5A.03	5.03	5.04	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00510	NONPATIENT TELEPHONES						5.01
5.02	00540	ADMITTING	-486,848	32,165,183				5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	875,466	-888,717	31,763,314		5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	0	6,556,046	0	6,655,273	135,482,354	5.04
7.00	00700	OPERATION OF PLANT	0	2,456,456	0	2,493,637	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	169,063	0	171,622	0	8.00
9.00	00900	HOUSEKEEPING	0	564,550	0	573,095	0	9.00
10.00	01000	DIETARY	0	353,175	0	358,521	0	10.00
11.00	01100	CAFETERIA	0	633,803	0	643,396	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,337,721	0	1,357,969	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	724,544	0	735,511	0	14.00
15.00	01500	PHARMACY	0	696,203	0	706,741	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	703,069	0	713,711	0	16.00
17.00	01700	SOCIAL SERVICE	0	7,888	0	8,007	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	0	2,742,501	0	2,784,011	10,633,278	30.00
31.00	03100	INTENSIVE CARE UNIT	0	866,322	0	879,435	2,320,234	31.00
43.00	04300	NURSERY	0	284,873	0	289,185	559,550	43.00
44.00	04400	SKILLED NURSING FACILITY	0	866,286	0	879,398	2,330,978	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	1,678,197	0	1,703,598	20,796,878	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	228,364	0	231,821	440,646	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,373,420	0	1,394,208	24,961,204	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	161,841	0	164,291	813,258	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	1,590,255	0	1,614,325	29,041,173	60.00
65.00	06500	RESPIRATORY THERAPY	0	652,423	0	662,298	4,709,357	65.00
66.00	06600	PHYSICAL THERAPY	0	997,061	0	1,012,153	4,516,832	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	140,529	0	142,656	2,400,617	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	173,616	0	176,244	5,439,134	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	518,023	0	525,864	3,459,343	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	981,260	0	996,112	9,558,649	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	107,972	0	109,606	1,081,322	76.01
76.02	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.02
76.03	03953	WOUND CARE	0	37,081	0	37,642	103,303	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	136,170	0	138,231	448,858	90.00
91.00	09100	EMERGENCY	0	1,023,386	0	1,038,876	11,867,740	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	-486,848	29,637,564	-888,717	29,197,437	135,482,354	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	64,435	0	65,410	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,428,198	0	1,449,815	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	65,798	0	66,794	0	194.00
194.01	07955	MARKETING	0	458,015	0	464,948	0	194.01
194.02	07952	SENIOR CIRCLE	0	5,733	0	5,820	0	194.02
194.03	07953	BUSINESS HEALTH	0	398,391	0	404,421	0	194.03
194.04	07954	VACANT SPACE	0	107,049	0	108,669	0	194.04
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)		486,848		888,717	6,841,491	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.015136		0.027979	0.050497	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet B-1

Date/Time Prepared:  
2/26/2014 2:00 pm

Cost Center Description		Reconciliation	ADMITTING (ACCUM. COST)	Reconciliation	CASHIERING/AC COUNTS RECEIVABLE (ACCUM. COST)	OTHER ADMINISTRATIVE AND GENERAL (GROSS CHARGES)	
		5A.02	5.02	5A.03	5.03	5.04	
204.00	Cost to be allocated (per Wkst. B, Part II)		12,866		18,767	179,962	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0.000400		0.000591	0.001328	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet B-1

Date/Time Prepared:  
2/26/2014 2:00 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTEs)	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	NONPATIENT TELEPHONES					5.01
5.02	00540	ADMINISTRATIVE					5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL					5.04
7.00	00700	OPERATION OF PLANT	194,549				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,932	275,860			8.00
9.00	00900	HOUSEKEEPING	811	0	190,806		9.00
10.00	01000	DIETARY	7,967	0	7,967	38,346	10.00
11.00	01100	CAFETERIA	3,528	0	3,528	0	11.00
13.00	01300	NURSING ADMINISTRATION	400	0	400	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,878	0	9,878	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,348	0	2,348	0	16.00
17.00	01700	SOCIAL SERVICE	383	0	383	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	16,681	115,423	16,681	22,303	3,585
31.00	03100	INTENSIVE CARE UNIT	2,939	15,953	2,939	2,465	967
43.00	04300	NURSERY	489	0	489	0	310
44.00	04400	SKILLED NURSING FACILITY	5,967	34,637	5,967	13,578	1,189
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	15,699	45,798	15,699	0	1,251
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	576	27,070	576	0	244
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,929	20	10,929	0	1,365
54.01	03630	ULTRA SOUND	0	0	0	0	0
56.00	05600	RADIOISOTOPE	712	0	712	0	83
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
60.00	06000	LABORATORY	4,526	0	4,526	0	1,537
65.00	06500	RESPIRATORY THERAPY	5,309	0	5,309	0	660
66.00	06600	PHYSICAL THERAPY	4,927	0	4,927	0	1,061
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	1,296	0	1,296	0	69
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	2,930	0	2,930	0	0
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.01	03951	SLEEP LAB	347	224	347	0	130
76.02	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.03	03953	WOUND CARE	0	24	0	0	41
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
90.00	09000	CLINIC	1,074	0	1,074	0	99
91.00	09100	EMERGENCY	4,758	34,800	4,758	0	1,092
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	107,406	273,949	103,663	38,346	16,857
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	923	0	923	0	25
192.00	19200	PHYSICIANS' PRIVATE OFFICES	76,262	0	76,262	0	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	3,541	0	3,541	0	0
194.01	07955	MARKETING	2,187	0	2,187	0	175
194.02	07952	SENIOR CIRCLE	0	0	0	0	3
194.03	07953	BUSINESS HEALTH	4,230	1,911	4,230	0	448
194.04	07954	VACANT SPACE	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	2,563,406	215,056	599,816	498,571	718,974
203.00		Unit cost multiplier (Wkst. B, Part I)	13.176146	0.779584	3.143591	13.001904	41.065456
204.00		Cost to be allocated (per Wkst. B, Part II)	212,137	35,026	16,722	156,206	41,395

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 150075			Period: From 10/01/2012 To 09/30/2013		Worksheet B-1 Date/Time Prepared: 2/26/2014 2:00 pm	
Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTEs)		
		7.00	8.00	9.00	10.00	11.00		
205.00	Unit cost multiplier (Wkst. B, Part II)	1.090404	0.126970	0.087639	4.073593	2.364348	205.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet B-1

Date/Time Prepared:  
2/26/2014 2:00 pm

Cost Center Description		NURSING ADMINISTRATION (FTEs IN NURSING AREAS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (% COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00540						5.02
5.03	00550						5.03
5.04	00560						5.04
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	8,679					13.00
14.00	01400	0	2,154,772				14.00
15.00	01500	0	61,559	939,365			15.00
16.00	01600	0	3,956	0	135,482,354		16.00
17.00	01700	0	0	0	0	15,955	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	3,585	207,260	0	10,633,278	5,751	30.00
31.00	03100	967	34,523	0	2,320,234	6,552	31.00
43.00	04300	310	0	0	559,550	504	43.00
44.00	04400	1,189	28,883	0	2,330,978	3,148	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	1,251	168,966	0	20,796,878	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	244	0	0	440,646	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	50,204	0	24,961,204	0	54.00
54.01	03630	0	0	0	0	0	54.01
56.00	05600	0	49,196	0	813,258	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	0	503,116	0	29,041,173	0	60.00
65.00	06500	0	17,248	0	4,709,357	0	65.00
66.00	06600	0	45,101	0	4,516,832	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	2,400,617	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	280,666	0	5,439,134	0	71.00
72.00	07200	0	523,723	0	3,459,343	0	72.00
73.00	07300	0	0	939,365	9,558,649	0	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	0	5,577	0	1,081,322	0	76.01
76.02	03952	0	0	0	0	0	76.02
76.03	03953	41	16,592	0	103,303	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
90.00	09000	0	17,465	0	448,858	0	90.00
91.00	09100	1,092	85,192	0	11,867,740	0	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		8,679	2,099,227	939,365	135,482,354	15,955	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	31,378	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07955	0	1,348	0	0	0	194.01
194.02	07952	0	105	0	0	0	194.02
194.03	07953	0	22,714	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00							200.00
201.00							201.00
202.00		1,452,960	928,178	779,848	815,877	14,481	202.00
203.00		167.410992	0.430755	0.830186	0.006022	0.907615	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet B-1

Date/Time Prepared:  
2/26/2014 2:00 pm

Cost Center Description		NURSING ADMINISTRATION (FTEs IN NURSING AREAS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (% COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	13,282	194,421	8,691	50,462	7,537	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.530361	0.090228	0.009252	0.000372	0.472391	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet C Part I Date/Time Prepared: 2/26/2014 2:00 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		4,956,968	0	4,956,968	30.00
31.00	03100 INTENSIVE CARE UNIT		1,350,043	0	1,350,043	31.00
43.00	04300 NURSERY		401,966	0	401,966	43.00
44.00	04400 SKILLED NURSING FACILITY		1,599,846	0	1,599,846	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		3,552,175	0	3,552,175	50.00
51.00	05100 RECOVERY ROOM		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		344,583	0	344,583	52.00
53.00	05300 ANESTHESIOLOGY		0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		3,100,053	0	3,100,053	54.00
54.01	03630 ULTRA SOUND		0	0	0	54.01
56.00	05600 RADIO SOTOPE		251,070	0	251,070	56.00
57.00	05700 CT SCAN		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00
60.00	06000 LABORATORY		3,654,613	0	3,654,613	60.00
65.00	06500 RESPIRATORY THERAPY	0	1,068,170	0	1,068,170	65.00
66.00	06600 PHYSICAL THERAPY	0	1,439,162	0	1,439,162	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY		306,312	0	306,312	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		609,487	0	609,487	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		961,692	0	961,692	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		2,391,892	0	2,391,892	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS		0	0	0	76.00
76.01	03951 SLEEP LAB		187,368	0	187,368	76.01
76.02	03952 OTHER ANCILLARY SERVICE COST CENTERS		0	0	0	76.02
76.03	03953 WOUND CARE		60,247	0	60,247	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC		0	0	0	88.00
90.00	09000 CLINIC		196,583	0	196,583	90.00
91.00	09100 EMERGENCY		2,107,828	0	2,107,828	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		920,977	0	920,977	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES		0	0	0	95.00
200.00	Subtotal (see instructions)		29,461,035	0	29,461,035	200.00
201.00	Less Observation Beds		920,977	0	920,977	201.00
202.00	Total (see instructions)		28,540,058	0	28,540,058	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet C Part I Date/Time Prepared: 2/26/2014 2:00 pm
		Title XVII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
9.00	10.00					
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	9,187,155		9,187,155	30.00
31.00	03100	INTENSIVE CARE UNIT	2,320,234		2,320,234	31.00
43.00	04300	NURSERY	559,550		559,550	43.00
44.00	04400	SKILLED NURSING FACILITY	2,330,978		2,330,978	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	6,253,326	14,543,552	20,796,878	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	337,066	103,580	440,646	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,998,892	19,962,312	24,961,204	54.00
54.01	03630	ULTRA SOUND	0	0	0	54.01
56.00	05600	RADIOISOTOPE	166,629	646,629	813,258	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
60.00	06000	LABORATORY	8,692,243	20,348,930	29,041,173	60.00
65.00	06500	RESPIRATORY THERAPY	4,376,198	333,159	4,709,357	65.00
66.00	06600	PHYSICAL THERAPY	2,414,051	2,102,781	4,516,832	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,246,728	1,153,889	2,400,617	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,552,001	1,887,133	5,439,134	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,100,435	1,358,908	3,459,343	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,133,442	4,425,207	9,558,649	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.00
76.01	03951	SLEEP LAB	0	1,081,322	1,081,322	76.01
76.02	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.02
76.03	03953	WOUND CARE	197	103,106	103,303	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
90.00	09000	CLINIC	81,080	367,778	448,858	90.00
91.00	09100	EMERGENCY	2,675,267	9,192,473	11,867,740	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	115,360	1,330,763	1,446,123	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
200.00		Subtotal (see instructions)	56,540,832	78,941,522	135,482,354	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	56,540,832	78,941,522	135,482,354	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet C Part I Date/Time Prepared: 2/26/2014 2:00 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital
		11.00		PPS
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.170803		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.781995		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.124195		54.00
54.01	03630 ULTRA SOUND	0.000000		54.01
56.00	05600 RADIOISOTOPE	0.308721		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000 LABORATORY	0.125842		60.00
65.00	06500 RESPIRATORY THERAPY	0.226819		65.00
66.00	06600 PHYSICAL THERAPY	0.318622		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.127597		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.112056		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.277998		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.250233		73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
76.01	03951 SLEEP LAB	0.173277		76.01
76.02	03952 OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.02
76.03	03953 WOUND CARE	0.583207		76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC			88.00
90.00	09000 CLINIC	0.437963		90.00
91.00	09100 EMERGENCY	0.177610		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.636859		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
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: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet C  
Part I  
Date/Time Prepared:  
2/26/2014 2:00 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS	4,956,968		4,956,968	0	4,956,968 30.00
31.00	03100 INTENSIVE CARE UNIT	1,350,043		1,350,043	0	1,350,043 31.00
43.00	04300 NURSERY	401,966		401,966	0	401,966 43.00
44.00	04400 SKILLED NURSING FACILITY	1,599,846		1,599,846	0	1,599,846 44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	3,552,175		3,552,175	0	3,552,175 50.00
51.00	05100 RECOVERY ROOM	0		0	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	344,583		344,583	0	344,583 52.00
53.00	05300 ANESTHESIOLOGY	0		0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,100,053		3,100,053	0	3,100,053 54.00
54.01	03630 ULTRA SOUND	0		0	0	0 54.01
56.00	05600 RADIO SOTOPE	251,070		251,070	0	251,070 56.00
57.00	05700 CT SCAN	0		0	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0 58.00
60.00	06000 LABORATORY	3,654,613		3,654,613	0	3,654,613 60.00
65.00	06500 RESPIRATORY THERAPY	1,068,170	0	1,068,170	0	1,068,170 65.00
66.00	06600 PHYSICAL THERAPY	1,439,162	0	1,439,162	0	1,439,162 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	306,312		306,312	0	306,312 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	609,487		609,487	0	609,487 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	961,692		961,692	0	961,692 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,391,892		2,391,892	0	2,391,892 73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0 76.00
76.01	03951 SLEEP LAB	187,368		187,368	0	187,368 76.01
76.02	03952 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0 76.02
76.03	03953 WOUND CARE	60,247		60,247	0	60,247 76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0		0	0	0 88.00
90.00	09000 CLINIC	196,583		196,583	0	196,583 90.00
91.00	09100 EMERGENCY	2,107,828		2,107,828	0	2,107,828 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	920,977		920,977	0	920,977 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES	0		0	0	0 95.00
200.00	Subtotal (see instructions)	29,461,035	0	29,461,035	0	29,461,035 200.00
201.00	Less Observation Beds	920,977		920,977	0	920,977 201.00
202.00	Total (see instructions)	28,540,058	0	28,540,058	0	28,540,058 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet C Part I Date/Time Prepared: 2/26/2014 2:00 pm
		Title XIX	Hospital	Cost

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	9,187,155		9,187,155	30.00
31.00	03100	INTENSIVE CARE UNIT	2,320,234		2,320,234	31.00
43.00	04300	NURSERY	559,550		559,550	43.00
44.00	04400	SKILLED NURSING FACILITY	2,330,978		2,330,978	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	6,253,326	14,543,552	20,796,878	0.170803 50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	337,066	103,580	440,646	0.781995 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,998,892	19,962,312	24,961,204	0.124195 54.00
54.01	03630	ULTRA SOUND	0	0	0	0.000000 54.01
56.00	05600	RADIOISOTOPE	166,629	646,629	813,258	0.308721 56.00
57.00	05700	CT SCAN	0	0	0	0.000000 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000 58.00
60.00	06000	LABORATORY	8,692,243	20,348,930	29,041,173	0.125842 60.00
65.00	06500	RESPIRATORY THERAPY	4,376,198	333,159	4,709,357	0.226819 65.00
66.00	06600	PHYSICAL THERAPY	2,414,051	2,102,781	4,516,832	0.318622 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000 68.00
69.00	06900	ELECTROCARDIOLOGY	1,246,728	1,153,889	2,400,617	0.127597 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,552,001	1,887,133	5,439,134	0.112056 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,100,435	1,358,908	3,459,343	0.277998 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,133,442	4,425,207	9,558,649	0.250233 73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000 76.00
76.01	03951	SLEEP LAB	0	1,081,322	1,081,322	0.173277 76.01
76.02	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000 76.02
76.03	03953	WOUND CARE	197	103,106	103,303	0.583207 76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000 88.00
90.00	09000	CLINIC	81,080	367,778	448,858	0.437963 90.00
91.00	09100	EMERGENCY	2,675,267	9,192,473	11,867,740	0.177610 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	115,360	1,330,763	1,446,123	0.636859 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000 95.00
200.00		Subtotal (see instructions)	56,540,832	78,941,522	135,482,354	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	56,540,832	78,941,522	135,482,354	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet C Part I Date/Time Prepared: 2/26/2014 2:00 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
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	03630 ULTRASOUND	0.000000		54.01
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000 LABORATORY	0.000000		60.00
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
76.01	03951 SLEEP LAB	0.000000		76.01
76.02	03952 OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.02
76.03	03953 WOUND CARE	0.000000		76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
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
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150075		Period: From 10/01/2012 To 09/30/2013		Worksheet D Part I Date/Time Prepared: 2/26/2014 2:00 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	489,820	0	489,820	7,702	63.60	30.00
31.00	INTENSIVE CARE UNIT	85,076		85,076	801	106.21	31.00
43.00	NURSERY	12,479		12,479	504	24.76	43.00
44.00	SKILLED NURSING FACILITY	190,644		190,644	3,148	60.56	44.00
200.00	Total (lines 30-199)	778,019		778,019	12,155		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	3,014	191,690				
31.00	INTENSIVE CARE UNIT	422	44,821				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	1,955	118,395				
200.00	Total (lines 30-199)	5,391	354,906				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part II Date/Time Prepared: 2/26/2014 2:00 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	371,270	20,796,878	0.017852	1,988,040	35,490	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	16,838	440,646	0.038212	1,200	46	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	266,442	24,961,204	0.010674	2,433,580	25,976	54.00
54.01	03630 ULTRA SOUND	0	0	0.000000	0	0	54.01
56.00	05600 RADIOISOTOPE	20,207	813,258	0.024847	80,817	2,008	56.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
60.00	06000 LABORATORY	189,735	29,041,173	0.006533	4,151,888	27,124	60.00
65.00	06500 RESPIRATORY THERAPY	115,955	4,709,357	0.024622	2,077,534	51,153	65.00
66.00	06600 PHYSICAL THERAPY	112,348	4,516,832	0.024873	310,551	7,724	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	19,417	2,400,617	0.008088	651,764	5,271	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	34,743	5,439,134	0.006388	1,494,668	9,548	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	53,655	3,459,343	0.015510	1,076,213	16,692	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	71,270	9,558,649	0.007456	2,063,008	15,382	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.01	03951 SLEEP LAB	9,646	1,081,322	0.008921	0	0	76.01
76.02	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.02
76.03	03953 WOUND CARE	1,891	103,303	0.018305	197	4	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
90.00	09000 CLINIC	23,893	448,858	0.053231	16,686	888	90.00
91.00	09100 EMERGENCY	131,607	11,867,740	0.011089	1,303,765	14,457	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	91,005	1,446,123	0.062930	53,789	3,385	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	1,529,922	121,084,437		17,703,700	215,148	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150075		Period: From 10/01/2012 To 09/30/2013		Worksheet D Part III Date/Time Prepared: 2/26/2014 2:00 pm	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	PPS Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
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	7,702	0.00	3,014	0		30.00
31.00	03100	INTENSIVE CARE UNIT	801	0.00	422	0		31.00
43.00	04300	NURSERY	504	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	3,148	0.00	1,955	0		44.00
200.00		Total (lines 30-199)	12,155		5,391	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet D  
Part IV  
Date/Time Prepared:  
2/26/2014 2:00 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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
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	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.02
76.03	03953	WOUND CARE	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet D  
Part IV  
Date/Time Prepared:  
2/26/2014 2:00 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	20,796,878	0.000000	0.000000	1,988,040	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	440,646	0.000000	0.000000	1,200	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	24,961,204	0.000000	0.000000	2,433,580	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	813,258	0.000000	0.000000	80,817	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	29,041,173	0.000000	0.000000	4,151,888	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,709,357	0.000000	0.000000	2,077,534	65.00
66.00	06600	PHYSICAL THERAPY	0	4,516,832	0.000000	0.000000	310,551	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,400,617	0.000000	0.000000	651,764	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,439,134	0.000000	0.000000	1,494,668	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,459,343	0.000000	0.000000	1,076,213	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,558,649	0.000000	0.000000	2,063,008	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.01	03951	SLEEP LAB	0	1,081,322	0.000000	0.000000	0	76.01
76.02	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.02
76.03	03953	WOUND CARE	0	103,303	0.000000	0.000000	197	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	448,858	0.000000	0.000000	16,686	90.00
91.00	09100	EMERGENCY	0	11,867,740	0.000000	0.000000	1,303,765	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,446,123	0.000000	0.000000	53,789	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	121,084,437			17,703,700	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part IV Date/Time Prepared: 2/26/2014 2:00 pm
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Cost Center Description	Title XVIII					
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 1/1	Outpatient Program Charges on/after 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 1/1	
	11.00	12.00	12.01	13.00	13.01	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	3,728,191	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	5,067,011	0	0	0	54.00
54.01 03630 ULTRA SOUND	0	0	0	0	0	54.01
56.00 05600 RADIOISOTOPE	0	210,967	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00 06000 LABORATORY	0	536,502	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	94,324	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	16	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	410,522	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	285,326	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	434,581	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1,376,504	0	0	0	73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01 03951 SLEEP LAB	0	296,215	0	0	0	76.01
76.02 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.02
76.03 03953 WOUND CARE	0	87,263	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00 09000 CLINIC	0	148,035	0	0	0	90.00
91.00 09100 EMERGENCY	0	1,796,039	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	408,248	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00 Total (lines 50-199)	0	14,879,744	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part V Date/Time Prepared: 2/26/2014 2:00 pm
		Title XVII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see inst.) before 1/1	PPS Reimbursed Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	1.00	2.00	2.01	3.00	4.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0.170803	3,728,191	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.781995	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.124195	5,067,011	0	0	0	54.00
54.01 03630 ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00 05600 RADIOISOTOPE	0.308721	210,967	0	0	0	56.00
57.00 05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00 06000 LABORATORY	0.125842	536,502	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.226819	94,324	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.318622	16	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.127597	410,522	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.112056	285,326	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.277998	434,581	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.250233	1,376,504	0	0	0	73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.01 03951 SLEEP LAB	0.173277	296,215	0	0	0	76.01
76.02 03952 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.02
76.03 03953 WOUND CARE	0.583207	87,263	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0.000000					88.00
90.00 09000 CLINIC	0.437963	148,035	0	0	0	90.00
91.00 09100 EMERGENCY	0.177610	1,796,039	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.636859	408,248	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES	0.000000			0		95.00
200.00	Subtotal (see instructions)		14,879,744	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges				0	201.00
202.00	Net Charges (line 200 +/- line 201)		14,879,744	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part V Date/Time Prepared: 2/26/2014 2:00 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Costs				PPS		
	PPS Services (see inst.) before 1/1	PPS Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	5.00	5.01	6.00	7.00			
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	636,786	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	629,297	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	65,130	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	67,514	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	21,394	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	52,381	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	31,972	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	120,813	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	344,447	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.00
76.01	03951	SLEEP LAB	51,327	0	0	0	76.01
76.02	03952	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.02
76.03	03953	WOUND CARE	50,892	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	64,834	0	0	0	90.00
91.00	09100	EMERGENCY	318,994	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	259,996	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES			0		95.00
200.00		Subtotal (see instructions)	2,715,782	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0		201.00
202.00		Net Charges (line 200 +/- line 201)	2,715,782	0	0	0	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150075 Component CCN: 155373	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part IV Date/Time Prepared: 2/26/2014 2:00 pm
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
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 03630 ULTRA SOUND	0	0	0	0	0	54.01
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
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
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01 03951 SLEEP LAB	0	0	0	0	0	76.01
76.02 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.02
76.03 03953 WOUND CARE	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150075  
Component CCN: 155373

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet D  
Part IV  
Date/Time Prepared:  
2/26/2014 2:00 pm

Title XVIII

Skilled Nursing Facility

PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	20,796,878	0.000000	0.000000	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	440,646	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	24,961,204	0.000000	0.000000	55,682	54.00
54.01	03630 ULTRA SOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600 RADIOISOTOPE	0	813,258	0.000000	0.000000	0	56.00
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
60.00	06000 LABORATORY	0	29,041,173	0.000000	0.000000	276,981	60.00
65.00	06500 RESPIRATORY THERAPY	0	4,709,357	0.000000	0.000000	552,340	65.00
66.00	06600 PHYSICAL THERAPY	0	4,516,832	0.000000	0.000000	1,108,927	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	2,400,617	0.000000	0.000000	9,627	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,439,134	0.000000	0.000000	264,901	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	3,459,343	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	9,558,649	0.000000	0.000000	478,323	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.01	03951 SLEEP LAB	0	1,081,322	0.000000	0.000000	0	76.01
76.02	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.02
76.03	03953 WOUND CARE	0	103,303	0.000000	0.000000	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000 CLINIC	0	448,858	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	11,867,740	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,446,123	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	121,084,437			2,746,781	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150075 Component CCN: 155373	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part IV Date/Time Prepared: 2/26/2014 2:00 pm
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 1/1	Outpatient Program Charges on/after 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 1/1	
		11.00	12.00	12.01	13.00	13.01	
<b>ANCILLARY SERVICE COST CENTERS</b>							
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	03630 ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951 SLEEP LAB	0	0	0	0	0	76.01
76.02	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.02
76.03	03953 WOUND CARE	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part V Date/Time Prepared: 2/26/2014 2:00 pm
		Title XIX	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see inst.) before 1/1	PPS Reimbursed Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	1.00	2.00	2.01	3.00	4.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0.170803	0	0	368,579	0	50.00
51.00 05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.781995	0	0	10,142	0	52.00
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.124195	0	0	847,011	0	54.00
54.01 03630 ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00 05600 RADIOISOTOPE	0.308721	0	0	6,970	0	56.00
57.00 05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00 06000 LABORATORY	0.125842	0	0	1,040,250	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.226819	0	0	18,045	0	65.00
66.00 06600 PHYSICAL THERAPY	0.318622	0	0	96,608	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.127597	0	0	55,776	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.112056	0	0	52,391	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.277998	0	0	28,600	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.250233	0	0	166,968	0	73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.01 03951 SLEEP LAB	0.173277	0	0	32,520	0	76.01
76.02 03952 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.02
76.03 03953 WOUND CARE	0.583207	0	0	3,306	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0.000000					88.00
90.00 09000 CLINIC	0.437963	0	0	17,628	0	90.00
91.00 09100 EMERGENCY	0.177610	0	0	581,198	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.636859	0	0	64,333	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES	0.000000	0	0	0		95.00
200.00	Subtotal (see instructions)		0	3,390,325	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)		0	3,390,325	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part V Date/Time Prepared: 2/26/2014 2:00 pm
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Cost Center Description	Title XIX Hospital Cost				
	Costs				
	PPS Services (see inst.) before 1/1	PPS Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	5.00	5.01	6.00	7.00	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0	0	62,954	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	7,931	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	105,195	0	54.00
54.01 03630 ULTRA SOUND	0	0	0	0	54.01
56.00 05600 RADIOISOTOPE	0	0	2,152	0	56.00
57.00 05700 CT SCAN	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00 06000 LABORATORY	0	0	130,907	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	4,093	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	30,781	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	7,117	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	5,871	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	7,951	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	41,781	0	73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.00
76.01 03951 SLEEP LAB	0	0	5,635	0	76.01
76.02 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.02
76.03 03953 WOUND CARE	0	0	1,928	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00 09000 CLINIC	0	0	7,720	0	90.00
91.00 09100 EMERGENCY	0	0	103,227	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	40,971	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00 09500 AMBULANCE SERVICES			0		95.00
200.00	Subtotal (see instructions)	0	566,214	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	566,214	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet D-1 Date/Time Prepared: 2/26/2014 2:00 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,702	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,702	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.		671	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,600	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)		3,014	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,956,968	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)		4,956,968	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		8,639,462	28.00
29.00	Private room charges (excluding swing-bed charges)		1,107,243	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		7,532,219	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.573759	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		1,650.14	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,345.04	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		305.10	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		175.05	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		117,459	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,839,509	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		643.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,939,780	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,939,780	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet D-1 Date/Time Prepared: 2/26/2014 2:00 pm		
Cost Center Description			Title XVIII		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	1,350,043	801	1,685.45	422	711,260	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,099,652	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,750,692	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)					236,511	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					215,148	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					451,659	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					5,299,033	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,431	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					643.59	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					920,977	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150075		Period: From 10/01/2012 To 09/30/2013		Worksheet D-1 Date/Time Prepared: 2/26/2014 2:00 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	489,820	4,956,968	0.098814	920,977	91,005	90.00
91.00	Nursing School cost	0	4,956,968	0.000000	920,977	0	91.00
92.00	Allied health cost	0	4,956,968	0.000000	920,977	0	92.00
93.00	All other Medical Education	0	4,956,968	0.000000	920,977	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150075 Component CCN: 155373	Period: From 10/01/2012 To 09/30/2013	Worksheet D-1 Date/Time Prepared: 2/26/2014 2:00 pm
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,148	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,148	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)		3,148	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)		1,955	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,599,846	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)		1,599,846	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,599,846	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet D-1	
		Component CCN: 155373		Date/Time Prepared: 2/26/2014 2:00 pm	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
Cost Center Description					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				49.00
PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				54.00
55.00	Target amount per discharge				55.00
56.00	Target amount (line 54 x line 55)				56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				57.00
58.00	Bonus payment (see instructions)				58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				61.00
62.00	Relief payment (see instructions)				62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)				1,599,846 70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				508.21 71.00
72.00	Program routine service cost (line 9 x line 71)				993,551 72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				0 73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				993,551 74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				0 75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				0.00 76.00
77.00	Program capital-related costs (line 9 x line 76)				0 77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				0 78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				0 79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				0 80.00
81.00	Inpatient routine service cost per diem limitation				0.00 81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				0 82.00
83.00	Reasonable inpatient routine service costs (see instructions)				993,551 83.00
84.00	Program inpatient ancillary services (see instructions)				670,985 84.00
85.00	Utilization review - physician compensation (see instructions)				0 85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				1,664,536 86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)				0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150075 Component CCN: 155373		Period: From 10/01/2012 To 09/30/2013		Worksheet D-1 Date/Time Prepared: 2/26/2014 2:00 pm	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet D-3 Date/Time Prepared: 2/26/2014 2:00 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		4,253,000	30.00
31.00	03100	INTENSIVE CARE UNIT		1,356,119	31.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.170803	1,988,040	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.781995	1,200	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.124195	2,433,580	54.00
54.01	03630	ULTRA SOUND	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0.308721	80,817	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
60.00	06000	LABORATORY	0.125842	4,151,888	60.00
65.00	06500	RESPIRATORY THERAPY	0.226819	2,077,534	65.00
66.00	06600	PHYSICAL THERAPY	0.318622	310,551	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.127597	651,764	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.112056	1,494,668	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.277998	1,076,213	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.250233	2,063,008	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.00
76.01	03951	SLEEP LAB	0.173277	0	76.01
76.02	03952	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.02
76.03	03953	WOUND CARE	0.583207	197	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.437963	16,686	90.00
91.00	09100	EMERGENCY	0.177610	1,303,765	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.636859	53,789	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		17,703,700	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		17,703,700	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150075 Component CCN: 155373	Period: From 10/01/2012 To 09/30/2013	Worksheet D-3 Date/Time Prepared: 2/26/2014 2:00 pm	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.170803	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.781995	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.124195	55,682	6,915	54.00
54.01	03630 ULTRA SOUND	0.000000	0	0	54.01
56.00	05600 RADIOISOTOPE	0.308721	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.125842	276,981	34,856	60.00
65.00	06500 RESPIRATORY THERAPY	0.226819	552,340	125,281	65.00
66.00	06600 PHYSICAL THERAPY	0.318622	1,108,927	353,329	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.127597	9,627	1,228	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.112056	264,901	29,684	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.277998	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.250233	478,323	119,692	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.01	03951 SLEEP LAB	0.173277	0	0	76.01
76.02	03952 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.02
76.03	03953 WOUND CARE	0.583207	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.437963	0	0	90.00
91.00	09100 EMERGENCY	0.177610	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.636859	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		2,746,781	670,985	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)		2,746,781		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet D-3 Date/Time Prepared: 2/26/2014 2:00 pm	
Cost Center Description		Title XIX	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		396,893	30.00
31.00	03100	INTENSIVE CARE UNIT		90,739	31.00
43.00	04300	NURSERY		51,360	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.170803	291,745	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.781995	22,912	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.124195	212,875	54.00
54.01	03630	ULTRA SOUND	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0.308721	5,364	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
60.00	06000	LABORATORY	0.125842	353,933	60.00
65.00	06500	RESPIRATORY THERAPY	0.226819	135,198	65.00
66.00	06600	PHYSICAL THERAPY	0.318622	7,804	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.127597	41,136	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.112056	121,643	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.277998	8,087	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.250233	221,113	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.00
76.01	03951	SLEEP LAB	0.173277	0	76.01
76.02	03952	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.02
76.03	03953	WOUND CARE	0.583207	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
90.00	09000	CLINIC	0.437963	3,139	90.00
91.00	09100	EMERGENCY	0.177610	117,219	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.636859	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,542,168	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)		1,542,168	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part A Date/Time Prepared: 2/26/2014 2:00 pm	
		Title XVII	Hospital	PPS	
		0	before 1/1	on/after 1/1	
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER PPS</b>					
1.00	DRG Amounts Other than Outlier Payments		4,576,258		1.00
2.00	Outlier payments for discharges. (see instructions)		6,590		2.00
2.01	Outlier reconciliation amount		0		2.01
3.00	Managed Care Simulated Payments		0		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		58.08		4.00
<b>Indirect Medical Education Adjustment</b>					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		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
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment. (see instructions)		0.000000		27.00
28.00	IME Adjustment (see instructions)		0		28.00
29.00	Total IME payment (sum of lines 22 and 28)		0		29.00
<b>Disproportionate Share Adjustment</b>					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		1.18		30.00
31.00	Percentage of Medicaid patient days (see instructions)		16.59		31.00
32.00	Sum of lines 30 and 31		17.77		32.00
33.00	Allowable disproportionate share percentage (see instructions)		4.30		33.00
34.00	Disproportionate share adjustment (see instructions)		196,779		34.00
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part A Date/Time Prepared: 2/26/2014 2:00 pm	
		Title XVII	Hospital	PPS	
		0	before 1/1	on/after 1/1	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0		46.00
47.00	Subtotal (see instructions)		4,779,627		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)		4,779,627		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		363,604		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)		5,143,231		59.00
60.00	Primary payer payments		10,140		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		5,133,091		61.00
62.00	Deductibles billed to program beneficiaries		670,708		62.00
63.00	Coinurance billed to program beneficiaries		11,115		63.00
64.00	Allowable bad debts (see instructions)		20,300		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		13,195		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		20,300		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		4,464,463		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0		68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.92	Bundled Model 1 discount amount		0		70.92
70.93	HVBP incentive payment (see instructions)		25,372		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		-6,407		70.94
70.95	Recovery of Accelerated Depreciation		0		70.95
70.96	Low Volume Payment-1 (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low Volume Payment-2 (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2013	100,912		70.97
70.98	Low Volume Payment-3		0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		4,584,340		71.00
71.01	Sequestration adjustment (see instructions)		45,843		71.01
72.00	Interim payments		4,612,965		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		-74,468		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0		75.00
<b>TO BE COMPLETED BY CONTRACTOR</b>					
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the Time Value of Money		0.00		94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part A Date/Time Prepared: 2/26/2014 2:00 pm	
		Title XVIII	Hospital	PPS	
			before 1/1	on/after 1/1	
		0	1.00	1.01	
95.00	Time Value of Money for operating expenses(see instructions)		0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)		0		96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part B Date/Time Prepared: 2/26/2014 2:00 pm
		Title XVIII	Hospital	PPS
			before 1/1	on/after 1/1
			1.00	1.01
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)		2,715,782	2.00
3.00	PPS payments		2,297,073	3.00
4.00	Outlier payment (see instructions)		2,300	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)		0	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		0	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)		0	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	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)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		2,299,373	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		554,041	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		1,745,332	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)		1,745,332	30.00
31.00	Primary payer payments		5	31.00
32.00	Subtotal (line 30 minus line 31)		1,745,327	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		50,442	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		32,787	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		50,442	36.00
37.00	Subtotal (see instructions)		1,778,114	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,778,114	40.00
40.01	Sequestration adjustment (see instructions)		17,781	40.01
41.00	Interim payments		1,757,788	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		2,545	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 150075		Period: From 10/01/2012 To 09/30/2013		Worksheet E-1 Part I Date/Time Prepared: 2/26/2014 2:00 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		4,612,965		1,757,788	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,612,965		1,757,788	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		2,545	6.01	
6.02	SETTLEMENT TO PROGRAM		74,468		0	6.02	
7.00	Total Medicare program liability (see instructions)		4,538,497		1,760,333	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 150075 Component CCN: 155373		Period: From 10/01/2012 To 09/30/2013		Worksheet E-1 Part I Date/Time Prepared: 2/26/2014 2:00 pm	
		Title XVIII		Skilled Nursing Facility		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		683,560		0		1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		683,560		0		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		35		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		683,595		0		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: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet E-1 Part II Date/Time Prepared: 2/26/2014 2:00 pm
		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			1,901 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			3,436 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6 line 2			1,399 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			7,072 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			135,482,354 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			225,942 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)			1,104,446 8.00
9.00	Sequestration adjustment amount (see instructions)			22,089 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			1,082,357 10.00
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			1,014,949 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)			67,408 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150075 Component CCN: 155373	Period: From 10/01/2012 To 09/30/2013	Worksheet E-3 Part VI Date/Time Prepared: 2/26/2014 2:00 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		738,141	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		738,141	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		47,641	6.00
7.00	Coinsurance		0	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)		690,500	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14)		690,500	15.00
15.01	Sequestration adjustment (see instructions)		6,905	15.01
16.00	Interim payments		683,560	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program line 15 minus 15.01, 16 and 17		35	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2		0	19.00

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

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet G

Date/Time Prepared:  
2/26/2014 2:00 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	-939,987	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	6,565,685	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,902,101	0	0	0	6.00
7.00	Inventory	808,492	0	0	0	7.00
8.00	Prepaid expenses	350,648	0	0	0	8.00
9.00	Other current assets	1,420,714	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)	6,303,451	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	3,844,900	0	0	0	12.00
13.00	Land improvements	721,388	0	0	0	13.00
14.00	Accumulated depreciation	-262,209	0	0	0	14.00
15.00	Buildings	21,397,165	0	0	0	15.00
16.00	Accumulated depreciation	-5,768,593	0	0	0	16.00
17.00	Leasehold improvements	4,310,057	0	0	0	17.00
18.00	Accumulated depreciation	-2,259,441	0	0	0	18.00
19.00	Fixed equipment	4,305,832	0	0	0	19.00
20.00	Accumulated depreciation	-2,554,922	0	0	0	20.00
21.00	Automobiles and trucks	43,800	0	0	0	21.00
22.00	Accumulated depreciation	-43,800	0	0	0	22.00
23.00	Major movable equipment	9,079,931	0	0	0	23.00
24.00	Accumulated depreciation	-6,589,064	0	0	0	24.00
25.00	Minor equipment depreciable	2,614,760	0	0	0	25.00
26.00	Accumulated depreciation	-506,381	0	0	0	26.00
27.00	HIT designated Assets	2,061,888	0	0	0	27.00
28.00	Accumulated depreciation	-98,882	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)	30,296,429	0	0	0	30.00
<b>OTHER ASSETS</b>						
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	3,381,008	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,381,008	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	39,980,888	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	957,683	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,310,586	0	0	0	38.00
39.00	Payroll taxes payable	-90	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	27,437,401	0	0	0	43.00
44.00	Other current liabilities	684,153	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	30,389,733	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	30,389,733	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	9,591,155	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)	9,591,155	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	39,980,888	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet G-1

Date/Time Prepared:  
2/26/2014 2:00 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		10,609,079		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-1,017,924				2.00
3.00	Total (sum of line 1 and line 2)		9,591,155		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		9,591,155		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)		9,591,155		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
2/26/2014 2:00 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	9,746,705		9,746,705	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	2,330,978		2,330,978	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)	12,077,683		12,077,683	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	2,320,234		2,320,234	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)	2,320,234		2,320,234	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	14,397,917		14,397,917	17.00
18.00	Ancillary services	39,352,091	68,418,482	107,770,573	18.00
19.00	Outpatient services	2,790,628	10,523,236	13,313,864	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	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)	56,540,636	78,941,718	135,482,354	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		39,533,001		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)		39,533,001		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150075

Period:  
From 10/01/2012  
To 09/30/2013

Worksheet G-3

Date/Time Prepared:  
2/26/2014 2:00 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	135,482,354	1.00
2.00	Less contractual allowances and discounts on patients' accounts	98,718,720	2.00
3.00	Net patient revenues (line 1 minus line 2)	36,763,634	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	39,533,001	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,769,367	5.00
<b>OTHER INCOME</b>			
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	21,924	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	346	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	46,962	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	EHR INCENTIVES	1,498,061	24.00
24.01	FITNESS REVENUE	205,561	24.01
24.02	SALE OF FIXED ASSETS	-26,941	24.02
24.03	MISC. REVENUE	5,530	24.03
25.00	Total other income (sum of lines 6-24)	1,751,443	25.00
26.00	Total (line 5 plus line 25)	-1,017,924	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)	-1,017,924	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150075	Period: From 10/01/2012 To 09/30/2013	Worksheet L Parts I-III Date/Time Prepared: 2/26/2014 2:00 pm
		Title XVII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		362,711	1.00
2.00	Capital DRG outlier payments		893	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		19.38	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		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 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		363,604	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00