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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140040	Period: From 05/01/2012 To 04/30/2013	Worksheet S Parts I-III Date/Time Prepared: 9/30/2013 9:23 am

PART I - COST REPORT STATUS

Provider use only

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

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GALESBURG COTTAGE HOSPITAL (140040) for the cost reporting period beginning 05/01/2012 and ending 04/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	195,370	-4,755	0	0	1.00
2.00	Subprovider - IPF	0	5,069	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	999	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	201,438	-4,755	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 9/30/2013 9:23 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 695 NORTH KELLOGG STREET	PO Box:			1.00
2.00	City: GALESBURG	State: IL	Zip Code: 61401	County: KNOX	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	GALESBURG COTTAGE HOSPITAL	140040	99914	1	07/06/1966	N	P	P	3.00
4.00	Subprovider - IPF	GALEBSURG COTTAGE PSYCH	14S040	99914	4	05/01/2006	N	P	N	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	GALESBURG COTTAGE SKILLED UNIT	145690	99914		01/11/1991	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)	05/01/2012	04/30/2013	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for 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	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	2,220	0	0	0	3	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.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-2 Part I Date/Time Prepared: 9/30/2013 9:23 am

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	1		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.	05/01/2012	04/16/2013	38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.			39.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME Average	Direct GME Average	
		1.00	2.00	3.00	
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)				
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings				
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N			63.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-2 Part I Date/Time Prepared: 9/30/2013 9:23 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	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. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

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

		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	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	117,882	246,724	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	449008	140.00

	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: COMMUNITY HEALTH SYSTEMS	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 52280	141.00
142.00	Street: 4000 MERIDIAN BOULEVARD	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.	Y	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

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							1.00	
	Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						1.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-2 Part II | Date/Time Prepared: 9/30/2013 9:23 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	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	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	08/27/2013	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-2 Part II Date/Time Prepared: 9/30/2013 9:23 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	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	12/31/2011	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CLINTON	BALLEW	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(615) 628-6621	CLINTON_BALLEW@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-2 Part II | Date/Time Prepared: 9/30/2013 9:23 am

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	08/27/2013			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		REVENUE MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HFS Supplemental Information | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-2 Part IX Date/Time Prepared: 9/30/2013 9:23 am

		Title V	Title XIX	
		1.00	2.00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE			
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient	Outpatient	
		1.00	2.00	
	CRITICAL ACCESS HOSPITALS			
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
	RCE DISALLOWANCE			
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
	PASS THROUGH COST			
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "O") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-3 Part I Date/Time Prepared: 9/30/2013 9:23 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	84	30,660	0.00	0	1.00
2.00	HMO						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)		84	30,660	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	12	4,380	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)		96	35,040	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	12	4,380		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	34	12,410		0	19.00
20.00	NURSING FACILITY	45.00	0	0		0	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC	99.00				0	25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		142				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-3 Part I | Date/Time Prepared: 9/30/2013 9:23 am

	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)	7,202	2,072	10,892			1.00
2.00	HMO	1,167	151				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)	7,202	2,072	10,892			7.00
8.00	INTENSIVE CARE UNIT	1,983	0	2,539			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		0	881			13.00
14.00	Total (see instructions)	9,185	2,072	14,312	0.00	350.06	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,276	31	2,586	0.00	15.97	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	6,920	0	7,581	0.00	31.68	19.00
20.00	NURSING FACILITY		0	0	0.00	0.00	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC	0	0	0	0.00	0.00	25.00
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	397.71	27.00
28.00	Observation Bed Days		0	919			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
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-3 Part I | Date/Time Prepared: 9/30/2013 9:23 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)		0	1,701	472	3,054	1.00
2.00	HMO			0			2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,701	472	3,054	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	171	4	193	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY	0.00					20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC	0.00					25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-3 Part II Date/Time Prepared: 9/30/2013 9:23 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	20,429,273	0	20,429,273	821,714.00	24.86	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	1,404,589	0	1,404,589	61,836.00	22.71	9.00
10.00	Excluded area salaries (see instructions)		896,889	-18,870	878,019	36,390.00	24.13	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		994,413	0	994,413	26,585.00	37.41	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		18,225	0	18,225	341.00	53.45	13.00
14.00	Home office salaries & wage-related costs		1,471,596	0	1,471,596	27,521.00	53.47	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		5,020,734	0	5,020,734			17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV line 25		0	0	0			18.00
19.00	Excluded areas		383,888	0	383,888			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
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits	4.00	103,246	0	103,246	4,104.00	25.16	26.00
27.00	Administrative & General	5.00	2,239,734	-146,261	2,093,473	101,975.00	20.53	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	464,428	0	464,428	22,357.00	20.77	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	575,801	0	575,801	48,798.00	11.80	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,111,018	64,321	1,175,339	35,855.00	32.78	38.00
39.00	Central Services and Supply	14.00	106,085	0	106,085	8,368.00	12.68	39.00
40.00	Pharmacy	15.00	703,668	0	703,668	22,366.00	31.46	40.00
41.00	Medical Records & Medical Records Library	16.00	333,653	0	333,653	21,361.00	15.62	41.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-3 Part II Date/Time Prepared: 9/30/2013 9:23 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
42.00	Social Service	17.00	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: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-3 Part III Date/Time Prepared: 9/30/2013 9:23 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		20,429,273	0	20,429,273	821,714.00	24.86	1.00
2.00	Excluded area salaries (see instructions)		2,301,478	-18,870	2,282,608	98,226.00	23.24	2.00
3.00	Subtotal salaries (line 1 minus line 2)		18,127,795	18,870	18,146,665	723,488.00	25.08	3.00
4.00	Subtotal other wages & related costs (see inst.)		2,484,234	0	2,484,234	54,447.00	45.63	4.00
5.00	Subtotal wage-related costs (see inst.)		5,020,734	0	5,020,734	0.00	27.67	5.00
6.00	Total (sum of lines 3 thru 5)		25,632,763	18,870	25,651,633	777,935.00	32.97	6.00
7.00	Total overhead cost (see instructions)		5,637,633	-81,940	5,555,693	265,184.00	20.95	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-3 Part IV Date/Time Prepared: 9/30/2013 9:23 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	484,998	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	3,211,742	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	35,890	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	22,595	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	19,891	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	58,071	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,417,837	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	12,107	19.00
20.00	State or Federal Unemployment Taxes	141,491	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,404,622	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	152,489	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-3 Part V Date/Time Prepared: 9/30/2013 9:23 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	1,012,638	0	1.00
2.00	Hospital	1,012,638	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	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	0	0	15.00
16.00	Hospital-Based-CMHC	0	0	16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-7 | Date/Time Prepared: 9/30/2013 9:23 am

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.			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	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	46	0	46	5.00
6.00		RVL	3	0	3	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	59	0	59	8.00
9.00		RMX	57	0	57	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	21	0	21	12.00
13.00		RUB	27	0	27	13.00
14.00		RUA	13	0	13	14.00
15.00		RVC	393	0	393	15.00
16.00		RVB	405	0	405	16.00
17.00		RVA	551	0	551	17.00
18.00		RHC	601	0	601	18.00
19.00		RHB	787	0	787	19.00
20.00		RHA	1,854	0	1,854	20.00
21.00		RMC	224	0	224	21.00
22.00		RMB	209	0	209	22.00
23.00		RMA	562	0	562	23.00
24.00		RLB	3	0	3	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	15	0	15	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	40	0	40	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	302	0	302	32.00
33.00		HC2	22	0	22	33.00
34.00		HC1	155	0	155	34.00
35.00		HB2	11	0	11	35.00
36.00		HB1	263	0	263	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	15	0	15	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	30	0	30	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	36	0	36	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	7	0	7	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	3	0	3	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	26	0	26	48.00
49.00		CC2	3	0	3	49.00
50.00		CC1	12	0	12	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	32	0	32	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	109	0	109	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-7 | Date/Time Prepared: 9/30/2013 9:23 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	1	0	1	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	23	0	23	199.00
200.00	TOTAL		6,920	0	6,920	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	
	SNF SERVICES			
201.00	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).	99914	99914	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)	4,770,056			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet S-10 | Date/Time Prepared: 9/30/2013 9:23 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.139240	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,254,762	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	4,166,434	5.00
6.00	Medicaid charges	49,621,801	6.00
7.00	Medicaid cost (line 1 times line 6)	6,909,340	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	19	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	743	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	103	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)	84	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	84	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	1,053,637	99,121	1,152,758	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	146,708	13,802	160,510	21.00
22.00	Partial payment by patients approved for charity care	320	0	320	22.00
23.00	Cost of charity care (line 21 minus line 22)	146,388	13,802	160,190	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)	4,652,240	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	470,061	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	4,182,179	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	582,327	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	742,517	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	742,601	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A | Date/Time Prepared: 9/30/2013 9:23 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		812,653	812,653	733,431	1,546,084	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,089,805	2,089,805	530,922	2,620,727	2.00
4.00	00400	EMPLOYEE BENEFITS	103,246	105,938	209,184	3,835,768	4,044,952	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,239,734	17,945,659	20,185,393	-4,925,552	15,259,841	5.00
7.00	00700	OPERATION OF PLANT	464,428	1,217,127	1,681,555	0	1,681,555	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	255,958	255,958	0	255,958	8.00
9.00	00900	HOUSEKEEPING	575,801	293,684	869,485	-35	869,450	9.00
10.00	01000	DIETARY	0	1,187,024	1,187,024	-608,194	578,830	10.00
11.00	01100	CAFETERIA	0	0	0	607,549	607,549	11.00
13.00	01300	NURSING ADMINISTRATION	1,111,018	237,564	1,348,582	63,106	1,411,688	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	106,085	3,627,755	3,733,840	-3,246,152	487,688	14.00
15.00	01500	PHARMACY	703,668	2,368,699	3,072,367	-2,275,303	797,064	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	333,653	416,207	749,860	-6,553	743,307	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,419,453	462,031	2,881,484	524,485	3,405,969	30.00
31.00	03100	INTENSIVE CARE UNIT	1,519,701	288,916	1,808,617	-4,722	1,803,895	31.00
40.00	04000	SUBPROVIDER - IPF	730,010	169,536	899,546	-1,742	897,804	40.00
43.00	04300	NURSERY	195	839	1,034	281,631	282,665	43.00
44.00	04400	SKILLED NURSING FACILITY	1,404,589	293,541	1,698,130	-20,659	1,677,471	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,310,140	1,333,299	2,643,439	521,919	3,165,358	50.00
51.00	05100	RECOVERY ROOM	420,652	43,444	464,096	-464,096	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	870,601	201,138	1,071,739	-816,327	255,412	52.00
53.00	05300	ANESTHESIOLOGY	1,477,920	254,763	1,732,683	0	1,732,683	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	695,743	860,702	1,556,445	1,250,848	2,807,293	54.00
54.01	05401	ULTRASOUND	102,130	36,601	138,731	-138,731	0	54.01
56.00	05600	RADIOISOTOPE	124,507	322,952	447,459	-447,459	0	56.00
57.00	05700	CT SCAN	143,455	320,996	464,451	-464,451	0	57.00
58.00	05800	MRI	113,958	285,221	399,179	-399,179	0	58.00
60.00	06000	LABORATORY	1,095,807	1,690,101	2,785,908	-13,895	2,772,013	60.00
65.00	06500	RESPIRATORY THERAPY	351,550	152,168	503,718	47,208	550,926	65.00
66.00	06600	PHYSICAL THERAPY	0	626,970	626,970	349,659	976,629	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	269,131	269,131	-269,131	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	80,528	80,528	-80,528	0	68.00
69.00	06900	ELECTROCARDIOLOGY	490,089	371,811	861,900	-606	861,294	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,002,270	1,002,270	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,155,803	2,155,803	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,132,951	2,132,951	73.00
74.00	07400	RENAL DIALYSIS	0	128,100	128,100	0	128,100	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	65,950	21,253	87,203	-87,203	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	163,195	442,656	605,851	-2,323	603,528	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	1,125,116	688,915	1,814,031	1,070,534	2,884,565	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	100,810	972,459	1,073,269	-1,073,269	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,363,204	40,876,144	61,239,348	-238,026	61,001,322	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	29,494	110,035	139,529	0	139,529	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,600	11,600	-11,600	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	249,726	249,726	194.01
194.02	07952	SENIOR CIRCLE	36,575	12,319	48,894	-100	48,794	194.02
194.03	07953	UNUSED SPACE	0	0	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118-199)	20,429,273	41,010,098	61,439,371	0	61,439,371	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A | Date/Time Prepared: 9/30/2013 9:23 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,107,752	3,653,836		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	55,470	2,676,197		2.00
4.00	00400	EMPLOYEE BENEFITS	-5,708	4,039,244		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-8,794,946	6,464,895		5.00
7.00	00700	OPERATION OF PLANT	-9,726	1,671,829		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	255,958		8.00
9.00	00900	HOUSEKEEPING	0	869,450		9.00
10.00	01000	DIETARY	0	578,830		10.00
11.00	01100	CAFETERIA	0	607,549		11.00
13.00	01300	NURSING ADMINISTRATION	-2,570	1,409,118		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	487,688		14.00
15.00	01500	PHARMACY	0	797,064		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,549	741,758		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,405,969		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,803,895		31.00
40.00	04000	SUBPROVIDER - IPF	0	897,804		40.00
43.00	04300	NURSERY	0	282,665		43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,677,471		44.00
45.00	04500	NURSING FACILITY	0	0		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	3,165,358		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	255,412		52.00
53.00	05300	ANESTHESIOLOGY	0	1,732,683		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,807,293		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	-83,350	2,688,663		60.00
65.00	06500	RESPIRATORY THERAPY	0	550,926		65.00
66.00	06600	PHYSICAL THERAPY	0	976,629		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	861,294		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,002,270		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,155,803		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,132,951		73.00
74.00	07400	RENAL DIALYSIS	0	128,100		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0		76.00
76.01	03561	SLEEP LAB	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
76.03	03950	WOUND CARE	0	603,528		76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00	09100	EMERGENCY	-1,249,505	1,635,060		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
99.00	09900	CMHC	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-7,984,132	53,017,190		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	139,529		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
194.01	07951	MARKETING	0	249,726		194.01
194.02	07952	SENIOR CIRCLE	0	48,794		194.02
194.03	07953	UNUSED SPACE	0	0		194.03
194.04	07954	GUEST MEALS	0	0		194.04
200.00		TOTAL (SUM OF LINES 118-199)	-7,984,132	53,455,239		200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet Non-CMS W | Date/Time Prepared: 9/30/2013 9:23 am

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00	EMPLOYEE BENEFITS	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
40.00	SUBPROVIDER - IPF	04000		40.00
43.00	NURSERY	04300		43.00
44.00	SKILLED NURSING FACILITY	04400		44.00
45.00	NURSING FACILITY	04500		45.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
54.01	ULTRASOUND	05401		54.01
56.00	RADIOISOTOPE	05600		56.00
57.00	CT SCAN	05700		57.00
58.00	MRI	05800		58.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
74.00	RENAL DIALYSIS	07400		74.00
76.00	OTHER ANCILLARY COSTS	03560		76.00
76.01	SLEEP LAB	03561		76.01
76.02	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	03550		76.02
76.03	WOUND CARE	03950		76.03
	OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC	08800		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	08900		89.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	AMBULANCE SERVICES	09500		95.00
99.00	CMHC	09900		99.00
101.00	HOME HEALTH AGENCY	10100		101.00
	SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	07950		194.00
194.01	MARKETING	07951		194.01
194.02	SENIOR CIRCLE	07952		194.02
194.03	UNUSED SPACE	07953		194.03
194.04	GUEST MEALS	07954		194.04
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-6 | Date/Time Prepared: 9/30/2013 9:23 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS	4.00	0	3,837,512	1.00
	TOTALS		0	3,837,512	
	B - OXYGEN COSTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	115,347	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	115,347	
	C - RENTAL AND LEASE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	11,600	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	525,722	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
	TOTALS		0	537,322	
	D - OTHER CAP COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	84,853	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	636,978	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,200	3.00
	TOTALS		0	727,031	
	E - MARKETING DEPT				
1.00	MARKETING	194.01	81,940	167,786	1.00
	TOTALS		81,940	167,786	
	F - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	886,923	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,155,803	2.00
3.00	OPERATING ROOM	50.00	0	88,129	3.00
	TOTALS		0	3,130,855	
	G - COST OF DRUGS/IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,132,951	1.00
	TOTALS		0	2,132,951	
	H - LABOR AND DELIV				
1.00	ADULTS & PEDIATRICS	30.00	433,101	99,825	1.00
2.00	NURSERY	43.00	228,983	52,648	2.00
	TOTALS		662,084	152,473	
	I - THERAPY COSTS				
1.00	PHYSICAL THERAPY	66.00	0	349,659	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	349,659	
	J - MISCELLANEOUS DEPTS				
1.00	NURSING ADMINISTRATION	13.00	64,321	7,043	1.00
2.00	OPERATING ROOM	50.00	420,652	43,444	2.00
3.00	RESPIRATORY THERAPY	65.00	65,950	21,253	3.00
4.00	EMERGENCY	91.00	100,810	972,459	4.00
	TOTALS		651,733	1,044,199	
	K - OTHER RADIOLOGY COSTS				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	484,050	965,770	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	TOTALS		484,050	965,770	
	L - DIETARY TO CAFETERIA				
1.00	CAFETERIA	11.00	0	607,549	1.00
	TOTALS		0	607,549	
500.00	Grand Total: Increases		1,879,807	13,768,454	500.00

RECLASSIFICATIONS | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-6 | Date/Time Prepared: 9/30/2013 9:23 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,837,512	0		1.00
	TOTALS		0	3,837,512			
	B - OXYGEN COSTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	115,297	50		1.00
2.00	OPERATING ROOM	50.00	0	50	0		2.00
	TOTALS		0	115,347			
	C - RENTAL AND LEASE						
1.00	EMPLOYEE BENEFITS	4.00	0	1,744	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	39,919	10		2.00
3.00	HOUSEKEEPING	9.00	0	35	0		3.00
4.00	DIETARY	10.00	0	645	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	8,258	0		5.00
6.00	PHARMACY	15.00	0	142,352	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	6,553	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	8,441	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	4,722	0		9.00
10.00	SUBPROVIDER - IPF	40.00	0	1,742	0		10.00
11.00	SKILLED NURSING FACILITY	44.00	0	20,659	0		11.00
12.00	OPERATING ROOM	50.00	0	30,256	0		12.00
14.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,770	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	198,972	0		15.00
18.00	LABORATORY	60.00	0	13,895	0		18.00
19.00	RESPIRATORY THERAPY	65.00	0	39,995	0		19.00
20.00	ELECTROCARDIOLOGY	69.00	0	606	0		20.00
21.00	WOUND CARE	76.03	0	2,323	0		21.00
22.00	EMERGENCY	91.00	0	2,735	0		22.00
23.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	11,600	0		23.00
24.00	SENIOR CIRCLE	194.02	0	100	0		24.00
	TOTALS		0	537,322			
	D - OTHER CAP COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	727,031	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	727,031			
	E - MARKETING DEPT						
1.00	ADMINISTRATIVE & GENERAL	5.00	81,940	167,786	0		1.00
	TOTALS		81,940	167,786			
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,130,855	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	3,130,855			
	G - COST OF DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	2,132,951	0		1.00
	TOTALS		0	2,132,951			
	H - LABOR AND DELIV						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	662,084	152,473	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		662,084	152,473			
	I - THERAPY COSTS						
1.00	OCCUPATIONAL THERAPY	67.00	0	269,131	0		1.00
2.00	SPEECH PATHOLOGY	68.00	0	80,528	0		2.00
	TOTALS		0	349,659			
	J - MISCELLANEOUS DEPTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	64,321	7,043	0		1.00
2.00	RECOVERY ROOM	51.00	420,652	43,444	0		2.00
3.00	SLEEP LAB	76.01	65,950	21,253	0		3.00
4.00	AMBULANCE SERVICES	95.00	100,810	972,459	0		4.00
	TOTALS		651,733	1,044,199			
	K - OTHER RADIOLOGY COSTS						
1.00	ULTRASOUND	54.01	102,130	36,601	0		1.00
2.00	RADIOISOTOPE	56.00	124,507	322,952	0		2.00
3.00	CT SCAN	57.00	143,455	320,996	0		3.00
4.00	MRI	58.00	113,958	285,221	0		4.00
	TOTALS		484,050	965,770			
	L - DIETARY TO CAFETERIA						
1.00	DIETARY	10.00	0	607,549	0		1.00
	TOTALS		0	607,549			
500.00	Grand Total: Decreases		1,879,807	13,768,454			500.00

RECLASSIFICATIONS | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 9/30/2013 9:23 am

	Increases			Decreases			
	Cost Center	Line #	Salary	Cost Center	Line #	Salary	
	2.00	3.00	4.00	6.00	7.00	8.00	
	A - EMPLOYEE BENEFITS						
1.00	EMPLOYEE BENEFITS	4.00	0	ADMINISTRATIVE & GENERAL	5.00	0	1.00
	TOTALS		0	TOTALS		0	
	B - OXYGEN COSTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	CENTRAL SERVICES & SUPPLY	14.00	0	1.00
2.00		0.00	0	OPERATING ROOM	50.00	0	2.00
	TOTALS		0	TOTALS		0	
	C - RENTAL AND LEASE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	EMPLOYEE BENEFITS	4.00	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	ADMINISTRATIVE & GENERAL	5.00	0	2.00
3.00		0.00	0	HOUSEKEEPING	9.00	0	3.00
4.00		0.00	0	DIETARY	10.00	0	4.00
5.00		0.00	0	NURSING ADMINISTRATION	13.00	0	5.00
6.00		0.00	0	PHARMACY	15.00	0	6.00
7.00		0.00	0	MEDICAL RECORDS & LIBRARY	16.00	0	7.00
8.00		0.00	0	ADULTS & PEDIATRICS	30.00	0	8.00
9.00		0.00	0	INTENSIVE CARE UNIT	31.00	0	9.00
10.00		0.00	0	SUBPROVIDER - IPF	40.00	0	10.00
11.00		0.00	0	SKILLED NURSING FACILITY	44.00	0	11.00
12.00		0.00	0	OPERATING ROOM	50.00	0	12.00
14.00		0.00	0	DELIVERY ROOM & LABOR ROOM	52.00	0	14.00
15.00		0.00	0	RADIOLOGY-DIAGNOSTIC	54.00	0	15.00
18.00		0.00	0	LABORATORY	60.00	0	18.00
19.00		0.00	0	RESPIRATORY THERAPY	65.00	0	19.00
20.00		0.00	0	ELECTROCARDIOLOGY	69.00	0	20.00
21.00		0.00	0	WOUND CARE	76.03	0	21.00
22.00		0.00	0	EMERGENCY	91.00	0	22.00
23.00		0.00	0	PHYSICIANS' PRIVATE OFFICES	192.00	0	23.00
24.00		0.00	0	SENIOR CIRCLE	194.02	0	24.00
	TOTALS		0	TOTALS		0	
	D - OTHER CAP COSTS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	ADMINISTRATIVE & GENERAL	5.00	0	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0		0.00	0	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0		0.00	0	3.00
	TOTALS		0	TOTALS		0	
	E - MARKETING DEPT						
1.00	MARKETING	194.01	81,940	ADMINISTRATIVE & GENERAL	5.00	81,940	1.00
	TOTALS		81,940	TOTALS		81,940	
	F - MEDICAL SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	CENTRAL SERVICES & SUPPLY	14.00	0	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0		0.00	0	2.00
3.00	OPERATING ROOM	50.00	0		0.00	0	3.00
	TOTALS		0	TOTALS		0	
	G - COST OF DRUGS/IV SOLUTIONS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	PHARMACY	15.00	0	1.00
	TOTALS		0	TOTALS		0	
	H - LABOR AND DELIV						
1.00	ADULTS & PEDIATRICS	30.00	433,101	DELIVERY ROOM & LABOR ROOM	52.00	662,084	1.00
2.00	NURSERY	43.00	228,983		0.00	0	2.00
	TOTALS		662,084	TOTALS		662,084	
	I - THERAPY COSTS						
1.00	PHYSICAL THERAPY	66.00	0	OCCUPATIONAL THERAPY	67.00	0	1.00
2.00		0.00	0	SPEECH PATHOLOGY	68.00	0	2.00
	TOTALS		0	TOTALS		0	
	J - MISCELLANEOUS DEPTS						
1.00	NURSING ADMINISTRATION	13.00	64,321	ADMINISTRATIVE & GENERAL	5.00	64,321	1.00
2.00	OPERATING ROOM	50.00	420,652	RECOVERY ROOM	51.00	420,652	2.00
3.00	RESPIRATORY THERAPY	65.00	65,950	SLEEP LAB	76.01	65,950	3.00
4.00	EMERGENCY	91.00	100,810	AMBULANCE SERVICES	95.00	100,810	4.00
	TOTALS		651,733	TOTALS		651,733	
	K - OTHER RADIOLOGY COSTS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	484,050	ULTRASOUND	54.01	102,130	1.00
2.00		0.00	0	RADIOISOTOPE	56.00	124,507	2.00
3.00		0.00	0	CT SCAN	57.00	143,455	3.00
4.00		0.00	0	MRI	58.00	113,958	4.00
	TOTALS		484,050	TOTALS		484,050	
	L - DIETARY TO CAFETERIA						
1.00	CAFETERIA	11.00	0	DIETARY	10.00	0	1.00
	TOTALS		0	TOTALS		0	
500.00	Grand Total: Increases		1,879,807	Grand Total: Decreases		1,879,807	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-7 Part I | Date/Time Prepared: 9/30/2013 9:23 am

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,943,661	0	0	0	0	1.00
2.00	Land Improvements	824,939	0	0	0	0	2.00
3.00	Buildings and Fixtures	56,948,844	816,067	0	816,067	0	3.00
4.00	Building Improvements	47,187,470	2,238,685	0	2,238,685	52,235	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	2,323,746	498,749	0	498,749	0	6.00
7.00	HIT designated Assets	363,018	410,576	0	410,576	0	7.00
8.00	Subtotal (sum of lines 1-7)	109,591,678	3,964,077	0	3,964,077	52,235	8.00
9.00	Reconciling Items	-234,444	0	0	0	-6,315	9.00
10.00	Total (line 8 minus line 9)	109,826,122	3,964,077	0	3,964,077	58,550	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,943,661	0	1.00
2.00	Land Improvements	824,939	0	2.00
3.00	Buildings and Fixtures	57,764,911	0	3.00
4.00	Building Improvements	49,373,920	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	2,822,495	0	6.00
7.00	HIT designated Assets	773,594	0	7.00
8.00	Subtotal (sum of lines 1-7)	113,503,520	0	8.00
9.00	Reconciling Items	-228,129	0	9.00
10.00	Total (line 8 minus line 9)	113,731,649	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-7 Part II | Date/Time Prepared: 9/30/2013 9:23 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	125,620	11,600	-46,398	84,853	636,978	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,190,126	894,479	0	5,200	0	2.00
3.00	Total (sum of lines 1-2)	1,315,746	906,079	-46,398	90,053	636,978	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	812,653		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,089,805		2.00
3.00	Total (sum of lines 1-2)	0	2,902,458		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-7 Part III Date/Time Prepared: 9/30/2013 9:23 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	65,736,893	0	65,736,893	0.578000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	47,994,756	0	47,994,756	0.422000	0	2.00
3.00	Total (sum of lines 1-2)	113,731,649	0	113,731,649	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	774,919	23,200	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,089,125	1,420,201	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,864,044	1,443,401	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	831,880	169,706	1,273,956	580,175	3,653,836	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	10,400	0	156,471	2,676,197	2.00
3.00	Total (sum of lines 1-2)	831,880	180,106	1,273,956	736,646	6,330,033	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-8 | Date/Time Prepared: 9/30/2013 9:23 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-22,070	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-9,860	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,335,425			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-41,383			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others	B	-2,893	CAP REL COSTS-BLDG & FIXT	1.00	14	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	-1,549	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-2,506	ADMINISTRATIVE & GENERAL	5.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	649,299	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-133,854	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
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	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
36.00	OTHER MISCELLANEOUS REVENUE	B	-23,670	ADMINISTRATIVE & GENERAL	5.00	0	36.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-8 | Date/Time Prepared: 9/30/2013 9:23 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
37.00	DEPRECIATION - ADMIN AND GENERAL	A	-6,352	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	HOSPITAL BAD DEBT	B	-5,584,816	ADMINISTRATIVE & GENERAL	5.00	0	38.00
40.00	PATIENT PHONES BENEFITS COST	A	-5,708	EMPLOYEE BENEFITS	4.00	0	40.00
41.00	PATIENT PHONES DEPRECIATION COST	A	-3,916	CAP REL COSTS-MVBLE EQUIP	2.00	9	41.00
42.00	PATIENT TV CABLE EXPENSE	A	-9,726	OPERATION OF PLANT	7.00	0	42.00
43.00	MARKETING EXP - EXCL MARKETING DEPT	A	-357,696	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	ILLINOIS PROVIDER TAX	A	-1,394,138	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	PHYSICIAN RECRUITING	A	-175,371	ADMINISTRATIVE & GENERAL	5.00	0	45.00
46.00	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-24,488	ADMINISTRATIVE & GENERAL	5.00	0	46.00
47.00	CHARITABLE CONTRIBUTIONS	A	-11,242	ADMINISTRATIVE & GENERAL	5.00	0	47.00
48.00	PENALTIES	A	-1,082	ADMINISTRATIVE & GENERAL	5.00	0	48.00
49.00	CLUB DUES	A	-3,395	ADMINISTRATIVE & GENERAL	5.00	0	49.00
49.01	MINORITY INTEREST	A	527,360	CAP REL COSTS-BLDG & FIXT	1.00	14	49.01
49.02	NONALLOWABLE LEGAL FEES	A	-7,012	ADMINISTRATIVE & GENERAL	5.00	0	49.02
49.06	MISCELLANEOUS NON-ALLOWABLE	A	-2,639	ADMINISTRATIVE & GENERAL	5.00	0	49.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,984,132				50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-8-1 | Date/Time Prepared: 9/30/2013 9:23 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL RELATED INTEREST	878,278	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	OPERATING INTEREST	28,548	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	PASI OPERATING COSTS	342,929	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS	28,678	0	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BLDG AND FIXTURES	27,030	0	4.01
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MVABLE EQUIPMENT	156,471	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	NON CAPITAL HO COSTS	1,286,844	0	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	0	-743,612	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	1,963,871	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	PASI FEES	0	542,116	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	401K FEES	0	2,249	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE	364,606	584,953	4.08
4.09	2.00	CAP REL COSTS-MVBLE EQUIP	CIG LEASED EQUIPMENT	276,204	229,575	4.09
4.11	5.00	ADMINISTRATIVE & GENERAL	AUDIT FEES	0	44,326	4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	MIS FEES	0	503,314	4.12
4.13	5.00	ADMINISTRATIVE & GENERAL	MANAGED CARE	0	23,244	4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	CASE MANAGEMENT	0	96,634	4.14
4.15	5.00	ADMINISTRATIVE & GENERAL	PURCHASE & ANCILLARY	0	7,935	4.15
4.16	5.00	ADMINISTRATIVE & GENERAL	EMERGENCY ROOM	0	49,045	4.16
4.17	5.00	ADMINISTRATIVE & GENERAL	PPSI FEES	0	16,149	4.17
4.18	5.00	ADMINISTRATIVE & GENERAL	COMPLIANCE/HIM/CCA FEES	0	28,346	4.18
4.19	5.00	ADMINISTRATIVE & GENERAL	SENIOR CIRCLE	0	18,124	4.19
4.20	5.00	ADMINISTRATIVE & GENERAL	EBOS FEES	0	1,412	4.20
4.21	5.00	ADMINISTRATIVE & GENERAL	PASI LIEN UNIT COLLECTION FEES	0	63,290	4.21
5.00	0		0	3,389,588	3,430,971	5.00

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

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

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

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

6.00	B		0.00	COMMUNITY HEALT	100.00	6.00
7.00	B		0.00	PASI	100.00	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: 140040	Period: From 05/01/2012 To 04/30/2013	Worksheet A-8-1 Date/Time Prepared: 9/30/2013 9:23 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	878,278	11		1.00
2.00	28,548	0		2.00
3.00	342,929	0		3.00
4.00	28,678	14		4.00
4.01	27,030	14		4.01
4.02	156,471	14		4.02
4.03	1,286,844	0		4.03
4.04	743,612	0		4.04
4.05	-1,963,871	0		4.05
4.06	-542,116	0		4.06
4.07	-2,249	0		4.07
4.08	-220,347	0		4.08
4.09	46,629	9		4.09
4.11	-44,326	0		4.11
4.12	-503,314	0		4.12
4.13	-23,244	0		4.13
4.14	-96,634	0		4.14
4.15	-7,935	0		4.15
4.16	-49,045	0		4.16
4.17	-16,149	0		4.17
4.18	-28,346	0		4.18
4.19	-18,124	0		4.19
4.20	-1,412	0		4.20
4.21	-63,290	0		4.21
5.00	-41,383			5.00

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

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

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

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

6.00	HOSPITAL COMPAN		6.00
7.00	COLLECTION AGEN		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: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet A-8-2 | Date/Time Prepared: 9/30/2013 9:23 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	13.00	DR. A	8,025	0	8,025	136,700	83	1.00
2.00	60.00	DR. B	83,350	83,350	0	219,500	0	2.00
3.00	91.00	DR. C	1,249,505	1,249,505	0	152,100	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,340,880	1,332,855	8,025		83	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	13.00	DR. A	5,455	273	0	0	0	1.00
2.00	60.00	DR. B	0	0	0	0	0	2.00
3.00	91.00	DR. C	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			5,455	273	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	13.00	DR. A	0	5,455	2,570	2,570		1.00
2.00	60.00	DR. B	0	0	0	83,350		2.00
3.00	91.00	DR. C	0	0	0	1,249,505		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	5,455	2,570	1,335,425		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B Part I | Date/Time Prepared: 9/30/2013 9:23 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,653,836	3,653,836				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,676,197		2,676,197			2.00
4.00	00400	EMPLOYEE BENEFITS	4,039,244	12,811	9,427	4,061,482		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,464,895	478,451	352,079	418,311	7,713,736	5.00
7.00	00700	OPERATION OF PLANT	1,671,829	1,087,179	800,028	92,801	3,651,837	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	255,958	27,120	19,957	0	303,035	8.00
9.00	00900	HOUSEKEEPING	869,450	38,964	28,672	115,055	1,052,141	9.00
10.00	01000	DIETARY	578,830	99,103	72,927	0	750,860	10.00
11.00	01100	CAFETERIA	607,549	48,284	35,531	0	691,364	11.00
13.00	01300	NURSING ADMINISTRATION	1,409,118	53,837	39,617	234,853	1,737,425	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	487,688	110,278	81,151	21,198	700,315	14.00
15.00	01500	PHARMACY	797,064	39,090	28,766	140,605	1,005,525	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	741,758	108,550	79,879	66,670	996,857	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,405,969	404,441	297,617	569,983	4,678,010	30.00
31.00	03100	INTENSIVE CARE UNIT	1,803,895	61,786	45,467	303,662	2,214,810	31.00
40.00	04000	SUBPROVIDER - IPF	897,804	84,425	62,126	145,868	1,190,223	40.00
43.00	04300	NURSERY	282,665	16,106	11,852	45,794	356,417	43.00
44.00	04400	SKILLED NURSING FACILITY	1,677,471	167,502	123,260	280,661	2,248,894	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,165,358	210,222	146,914	345,842	3,868,336	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	255,412	0	0	41,665	297,077	52.00
53.00	05300	ANESTHESIOLOGY	1,732,683	4,931	3,629	295,314	2,036,557	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,807,293	154,495	113,689	235,743	3,311,220	54.00
54.01	05401	ULTRASOUND	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	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,688,663	84,575	62,236	218,961	3,054,435	60.00
65.00	06500	RESPIRATORY THERAPY	550,926	31,752	23,365	83,424	689,467	65.00
66.00	06600	PHYSICAL THERAPY	976,629	17,212	12,666	0	1,006,507	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	861,294	99,494	73,215	97,928	1,131,931	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,002,270	0	0	0	1,002,270	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,155,803	0	0	0	2,155,803	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,132,951	0	0	0	2,132,951	73.00
74.00	07400	RENAL DIALYSIS	128,100	0	0	0	128,100	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	603,528	64,793	47,680	32,609	748,610	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	1,635,060	71,694	52,758	244,961	2,004,473	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	53,017,190	3,577,095	2,624,508	4,031,908	52,859,186	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	139,529	33,699	24,798	5,893	203,919	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,703	3,094	0	13,797	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	249,726	0	0	16,373	266,099	194.01
194.02	07952	SENIOR CIRCLE	48,794	0	0	7,308	56,102	194.02
194.03	07953	UNUSED SPACE	0	32,339	23,797	0	56,136	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	53,455,239	3,653,836	2,676,197	4,061,482	53,455,239	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B Part I | Date/Time Prepared: 9/30/2013 9:23 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,713,736					5.00
7.00	00700	OPERATION OF PLANT	615,838	4,267,675				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	51,103	55,768	409,906			8.00
9.00	00900	HOUSEKEEPING	177,431	80,122	0	1,309,694		9.00
10.00	01000	DIETARY	126,624	203,787	0	64,596	1,145,867	10.00
11.00	01100	CAFETERIA	116,590	99,287	0	31,472	0	11.00
13.00	01300	NURSING ADMINISTRATION	292,996	110,706	0	35,092	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	118,100	226,767	4,824	71,881	0	14.00
15.00	01500	PHARMACY	169,570	80,382	0	25,480	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	168,108	223,213	0	70,754	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	788,871	831,657	96,593	263,620	504,187	30.00
31.00	03100	INTENSIVE CARE UNIT	373,501	127,053	40,078	40,273	57,297	31.00
40.00	04000	SUBPROVIDER - IPF	200,717	173,605	19,316	55,029	126,043	40.00
43.00	04300	NURSERY	60,105	33,119	0	10,498	0	43.00
44.00	04400	SKILLED NURSING FACILITY	379,249	344,438	49,557	109,180	332,297	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	652,348	432,283	55,649	137,025	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	50,098	0	27,745	0	45,831	52.00
53.00	05300	ANESTHESIOLOGY	343,441	10,140	259	3,214	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	558,398	317,691	22,318	100,702	0	54.00
54.01	05401	ULTRASOUND	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	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	515,094	173,913	2,165	55,127	0	60.00
65.00	06500	RESPIRATORY THERAPY	116,270	65,291	592	20,696	0	65.00
66.00	06600	PHYSICAL THERAPY	169,735	35,394	0	11,219	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	190,887	204,592	6,303	64,852	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	169,021	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	363,550	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	359,697	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	21,603	0	31,540	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	126,244	133,236	6,325	42,233	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	338,030	147,427	44,384	46,731	80,212	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,613,219	4,109,871	407,648	1,259,674	1,145,867	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	34,388	69,295	0	21,965	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,327	22,009	2,258	6,976	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	44,874	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	9,461	0	0	0	0	194.02
194.03	07953	UNUSED SPACE	9,467	66,500	0	21,079	0	194.03
194.04	07954	GUEST MEALS	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)	7,713,736	4,267,675	409,906	1,309,694	1,145,867	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B Part I | Date/Time Prepared: 9/30/2013 9:23 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	938,713					11.00
13.00	01300	NURSING ADMINISTRATION	52,230	2,228,449				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,179	22,364	1,156,430			14.00
15.00	01500	PHARMACY	32,568	0	2,749	1,316,274		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	31,114	0	3,002	0	1,493,048	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	170,807	601,356	45,992	0	108,657	30.00
31.00	03100	INTENSIVE CARE UNIT	79,981	320,371	27,040	0	47,461	31.00
40.00	04000	SUBPROVIDER - IPF	44,050	153,895	4,980	0	27,290	40.00
43.00	04300	NURSERY	12,330	48,313	171	0	6,003	43.00
44.00	04400	SKILLED NURSING FACILITY	90,069	0	23,875	0	18,875	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	98,764	364,872	175,727	0	309,333	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,209	43,958	22,494	0	5,462	52.00
53.00	05300	ANESTHESIOLOGY	25,630	311,563	19,841	0	119,257	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	65,590	0	23,035	0	214,990	54.00
54.01	05401	ULTRASOUND	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	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	83,465	0	112,496	0	244,542	60.00
65.00	06500	RESPIRATORY THERAPY	29,326	0	15,847	0	23,302	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	23,265	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	26,630	103,317	3,307	0	41,876	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	185,029	0	44,903	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	449,740	0	61,976	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,316,274	83,679	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	2,000	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	0	0	3,025	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	8,392	0	10,087	0	13,041	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	55,411	258,440	27,942	0	97,136	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	929,745	2,228,449	1,156,379	1,316,274	1,493,048	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,787	0	33	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	3,151	0	18	0	0	194.01
194.02	07952	SENIOR CIRCLE	3,030	0	0	0	0	194.02
194.03	07953	UNUSED SPACE	0	0	0	0	0	194.03
194.04	07954	GUEST MEALS	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)	938,713	2,228,449	1,156,430	1,316,274	1,493,048	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B Part I | Date/Time Prepared: 9/30/2013 9:23 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	8,089,750	0	8,089,750		30.00
31.00	03100	INTENSIVE CARE UNIT	3,327,865	0	3,327,865		31.00
40.00	04000	SUBPROVIDER - IPF	1,995,148	0	1,995,148		40.00
43.00	04300	NURSERY	526,956	0	526,956		43.00
44.00	04400	SKILLED NURSING FACILITY	3,596,434	0	3,596,434		44.00
45.00	04500	NURSING FACILITY	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	6,094,337	0	6,094,337		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	503,874	0	503,874		52.00
53.00	05300	ANESTHESIOLOGY	2,869,902	0	2,869,902		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,613,944	0	4,613,944		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	4,241,237	0	4,241,237		60.00
65.00	06500	RESPIRATORY THERAPY	960,791	0	960,791		65.00
66.00	06600	PHYSICAL THERAPY	1,246,120	0	1,246,120		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	1,773,695	0	1,773,695		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,401,223	0	1,401,223		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,031,069	0	3,031,069		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,892,601	0	3,892,601		73.00
74.00	07400	RENAL DIALYSIS	183,243	0	183,243		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0		76.00
76.01	03561	SLEEP LAB	3,025	0	3,025		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.02
76.03	03950	WOUND CARE	1,088,168	0	1,088,168		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	3,100,186	0	3,100,186		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
99.00	09900	CMHC	0	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	52,539,568	0	52,539,568		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	332,387	0	332,387		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	47,367	0	47,367		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.00
194.01	07951	MARKETING	314,142	0	314,142		194.01
194.02	07952	SENIOR CIRCLE	68,593	0	68,593		194.02
194.03	07953	UNUSED SPACE	153,182	0	153,182		194.03
194.04	07954	GUEST MEALS	0	0	0		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	53,455,239	0	53,455,239		202.00

COST ALLOCATION STATISTICS | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet Non-CMS W | Date/Time Prepared: 9/30/2013 9:23 am

	Cost Center Description	Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	18	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	2	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	3	MEALS SERVED	10.00
11.00	CAFETERIA	4	FTE'S	11.00
13.00	NURSING ADMINISTRATION	5	NURSING WA GES	13.00
14.00	CENTRAL SERVICES & SUPPLY	6	COSTED REQUIS.	14.00
15.00	PHARMACY	7	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS CHAR GES	16.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B Part II | Date/Time Prepared: 9/30/2013 9:23 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0	12,811	9,427	22,238	22,238	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	478,451	352,079	830,530	2,290	5.00
7.00	00700	OPERATION OF PLANT	0	1,087,179	800,028	1,887,207	508	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	27,120	19,957	47,077	0	8.00
9.00	00900	HOUSEKEEPING	0	38,964	28,672	67,636	630	9.00
10.00	01000	DIETARY	0	99,103	72,927	172,030	0	10.00
11.00	01100	CAFETERIA	0	48,284	35,531	83,815	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	53,837	39,617	93,454	1,286	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	110,278	81,151	191,429	116	14.00
15.00	01500	PHARMACY	0	39,090	28,766	67,856	770	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	108,550	79,879	188,429	365	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	404,441	297,617	702,058	3,120	30.00
31.00	03100	INTENSIVE CARE UNIT	0	61,786	45,467	107,253	1,663	31.00
40.00	04000	SUBPROVIDER - IPF	0	84,425	62,126	146,551	799	40.00
43.00	04300	NURSERY	0	16,106	11,852	27,958	251	43.00
44.00	04400	SKILLED NURSING FACILITY	0	167,502	123,260	290,762	1,537	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	210,222	146,914	357,136	1,893	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	228	52.00
53.00	05300	ANESTHESIOLOGY	0	4,931	3,629	8,560	1,617	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	154,495	113,689	268,184	1,291	54.00
54.01	05401	ULTRASOUND	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	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	84,575	62,236	146,811	1,199	60.00
65.00	06500	RESPIRATORY THERAPY	0	31,752	23,365	55,117	457	65.00
66.00	06600	PHYSICAL THERAPY	0	17,212	12,666	29,878	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	99,494	73,215	172,709	536	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	64,793	47,680	112,473	179	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	71,694	52,758	124,452	1,341	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,577,095	2,624,508	6,201,603	22,076	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	33,699	24,798	58,497	32	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,703	3,094	13,797	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	90	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	40	194.02
194.03	07953	UNUSED SPACE	0	32,339	23,797	56,136	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	3,653,836	2,676,197	6,330,033	22,238	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B Part II | Date/Time Prepared: 9/30/2013 9:23 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	832,820					5.00
7.00	00700	OPERATION OF PLANT	66,489	1,954,204				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,517	25,537	78,131			8.00
9.00	00900	HOUSEKEEPING	19,156	36,688	0	124,110		9.00
10.00	01000	DIETARY	13,671	93,316	0	6,121	285,138	10.00
11.00	01100	CAFETERIA	12,588	45,465	0	2,982	0	11.00
13.00	01300	NURSING ADMINISTRATION	31,633	50,693	0	3,325	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,751	103,838	920	6,812	0	14.00
15.00	01500	PHARMACY	18,308	36,808	0	2,415	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	18,150	102,211	0	6,705	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	85,178	380,823	18,411	24,981	125,463	30.00
31.00	03100	INTENSIVE CARE UNIT	40,325	58,179	7,639	3,816	14,258	31.00
40.00	04000	SUBPROVIDER - IPF	21,670	79,495	3,682	5,215	31,364	40.00
43.00	04300	NURSERY	6,489	15,166	0	995	0	43.00
44.00	04400	SKILLED NURSING FACILITY	40,946	157,721	9,446	10,346	82,689	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	70,431	197,946	10,607	12,985	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,409	0	5,288	0	11,404	52.00
53.00	05300	ANESTHESIOLOGY	37,080	4,643	49	305	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	60,287	145,473	4,254	9,543	0	54.00
54.01	05401	ULTRASOUND	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	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	55,612	79,636	413	5,224	0	60.00
65.00	06500	RESPIRATORY THERAPY	12,553	29,897	113	1,961	0	65.00
66.00	06600	PHYSICAL THERAPY	18,325	16,207	0	1,063	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	20,609	93,684	1,201	6,146	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	18,248	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	39,251	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	38,835	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,332	0	6,012	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	13,630	61,010	1,206	4,002	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	36,495	67,508	8,460	4,428	19,960	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	821,968	1,881,944	77,701	119,370	285,138	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,713	31,731	0	2,081	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	251	10,078	430	661	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	4,845	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	1,021	0	0	0	0	194.02
194.03	07953	UNUSED SPACE	1,022	30,451	0	1,998	0	194.03
194.04	07954	GUEST MEALS	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)	832,820	1,954,204	78,131	124,110	285,138	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B Part II | Date/Time Prepared: 9/30/2013 9:23 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	144,850					11.00
13.00	01300	NURSING ADMINISTRATION	8,059	188,450				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,879	1,891	319,636			14.00
15.00	01500	PHARMACY	5,025	0	760	131,942		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,801	0	830	0	321,491	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,359	50,856	12,712	0	23,396	30.00
31.00	03100	INTENSIVE CARE UNIT	12,342	27,092	7,474	0	10,219	31.00
40.00	04000	SUBPROVIDER - IPF	6,797	13,014	1,376	0	5,876	40.00
43.00	04300	NURSERY	1,903	4,086	47	0	1,292	43.00
44.00	04400	SKILLED NURSING FACILITY	13,898	0	6,599	0	4,064	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,240	30,855	48,571	0	66,621	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,730	3,717	6,217	0	1,176	52.00
53.00	05300	ANESTHESIOLOGY	3,955	26,347	5,484	0	25,678	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,121	0	6,367	0	46,290	54.00
54.01	05401	ULTRASOUND	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	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	12,879	0	31,094	0	52,653	60.00
65.00	06500	RESPIRATORY THERAPY	4,525	0	4,380	0	5,017	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	5,009	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	4,109	8,737	914	0	9,017	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	51,142	0	9,668	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	124,308	0	13,344	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	131,942	18,017	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	431	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	0	0	836	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	1,295	0	2,788	0	2,808	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	8,550	21,855	7,723	0	20,915	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	143,467	188,450	319,622	131,942	321,491	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	430	0	9	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	486	0	5	0	0	194.01
194.02	07952	SENIOR CIRCLE	467	0	0	0	0	194.02
194.03	07953	UNUSED SPACE	0	0	0	0	0	194.03
194.04	07954	GUEST MEALS	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)	144,850	188,450	319,636	131,942	321,491	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B Part II | Date/Time Prepared: 9/30/2013 9:23 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,453,357	0	1,453,357		30.00
31.00	03100	INTENSIVE CARE UNIT	290,260	0	290,260		31.00
40.00	04000	SUBPROVIDER - IPF	315,839	0	315,839		40.00
43.00	04300	NURSERY	58,187	0	58,187		43.00
44.00	04400	SKILLED NURSING FACILITY	618,008	0	618,008		44.00
45.00	04500	NURSING FACILITY	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	812,285	0	812,285		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	35,169	0	35,169		52.00
53.00	05300	ANESTHESIOLOGY	113,718	0	113,718		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	551,810	0	551,810		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	385,521	0	385,521		60.00
65.00	06500	RESPIRATORY THERAPY	114,020	0	114,020		65.00
66.00	06600	PHYSICAL THERAPY	70,482	0	70,482		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	317,662	0	317,662		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	79,058	0	79,058		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	176,903	0	176,903		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	188,794	0	188,794		73.00
74.00	07400	RENAL DIALYSIS	8,775	0	8,775		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0		76.00
76.01	03561	SLEEP LAB	836	0	836		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.02
76.03	03950	WOUND CARE	199,391	0	199,391		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	321,687	0	321,687		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
99.00	09900	CMHC	0	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,111,762	0	6,111,762		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	96,493	0	96,493		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	25,217	0	25,217		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.00
194.01	07951	MARKETING	5,426	0	5,426		194.01
194.02	07952	SENIOR CIRCLE	1,528	0	1,528		194.02
194.03	07953	UNUSED SPACE	89,607	0	89,607		194.03
194.04	07954	GUEST MEALS	0	0	0		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	6,330,033	0	6,330,033		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B-1 | Date/Time Prepared: 9/30/2013 9:23 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	317,149					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		315,667				2.00
4.00	00400	EMPLOYEE BENEFITS	1,112	1,112	20,326,027			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	41,529	41,529	2,093,473	-7,713,736	45,741,503	5.00
7.00	00700	OPERATION OF PLANT	94,366	94,366	464,428	0	3,651,837	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,354	2,354	0	0	303,035	8.00
9.00	00900	HOUSEKEEPING	3,382	3,382	575,801	0	1,052,141	9.00
10.00	01000	DIETARY	8,602	8,602	0	0	750,860	10.00
11.00	01100	CAFETERIA	4,191	4,191	0	0	691,364	11.00
13.00	01300	NURSING ADMINISTRATION	4,673	4,673	1,175,339	0	1,737,425	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,572	9,572	106,085	0	700,315	14.00
15.00	01500	PHARMACY	3,393	3,393	703,668	0	1,005,525	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,422	9,422	333,653	0	996,857	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,105	35,105	2,852,554	0	4,678,010	30.00
31.00	03100	INTENSIVE CARE UNIT	5,363	5,363	1,519,701	0	2,214,810	31.00
40.00	04000	SUBPROVIDER - IPF	7,328	7,328	730,010	0	1,190,223	40.00
43.00	04300	NURSERY	1,398	1,398	229,178	0	356,417	43.00
44.00	04400	SKILLED NURSING FACILITY	14,539	14,539	1,404,589	0	2,248,894	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,247	17,329	1,730,792	0	3,868,336	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	208,517	0	297,077	52.00
53.00	05300	ANESTHESIOLOGY	428	428	1,477,920	0	2,036,557	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,410	13,410	1,179,793	0	3,311,220	54.00
54.01	05401	ULTRASOUND	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	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	7,341	7,341	1,095,807	0	3,054,435	60.00
65.00	06500	RESPIRATORY THERAPY	2,756	2,756	417,500	0	689,467	65.00
66.00	06600	PHYSICAL THERAPY	1,494	1,494	0	0	1,006,507	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	8,636	8,636	490,089	0	1,131,931	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,002,270	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,155,803	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,132,951	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	128,100	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	5,624	5,624	163,195	0	748,610	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	6,223	6,223	1,225,926	0	2,004,473	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	310,488	309,570	20,178,018	-7,713,736	45,145,450	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,925	2,925	29,494	0	203,919	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	929	365	0	0	13,797	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	81,940	0	266,099	194.01
194.02	07952	SENIOR CIRCLE	0	0	36,575	0	56,102	194.02
194.03	07953	UNUSED SPACE	2,807	2,807	0	0	56,136	194.03
194.04	07954	GUEST MEALS	0	0	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)	3,653,836	2,676,197	4,061,482		7,713,736	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.520881	8.477912	0.199817		0.168638	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B-1 | Date/Time Prepared: 9/30/2013 9:23 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
204.00		Cost to be allocated (per Wkst. B, Part II)			22,238		832,820	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001094		0.018207	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B-1 | Date/Time Prepared: 9/30/2013 9:23 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	180,142					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,354	527,633				8.00
9.00	00900	HOUSEKEEPING	3,382	0	174,406			9.00
10.00	01000	DIETARY	8,602	0	8,602	66,156		10.00
11.00	01100	CAFETERIA	4,191	0	4,191	0	30,985	11.00
13.00	01300	NURSING ADMINISTRATION	4,673	0	4,673	0	1,724	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,572	6,210	9,572	0	402	14.00
15.00	01500	PHARMACY	3,393	0	3,393	0	1,075	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,422	0	9,422	0	1,027	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,105	124,335	35,105	29,109	5,638	30.00
31.00	03100	INTENSIVE CARE UNIT	5,363	51,588	5,363	3,308	2,640	31.00
40.00	04000	SUBPROVIDER - IPF	7,328	24,864	7,328	7,277	1,454	40.00
43.00	04300	NURSERY	1,398	0	1,398	0	407	43.00
44.00	04400	SKILLED NURSING FACILITY	14,539	63,790	14,539	19,185	2,973	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,247	71,632	18,247	0	3,260	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	35,713	0	2,646	370	52.00
53.00	05300	ANESTHESIOLOGY	428	334	428	0	846	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,410	28,728	13,410	0	2,165	54.00
54.01	05401	ULTRASOUND	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	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	7,341	2,787	7,341	0	2,755	60.00
65.00	06500	RESPIRATORY THERAPY	2,756	762	2,756	0	968	65.00
66.00	06600	PHYSICAL THERAPY	1,494	0	1,494	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	8,636	8,113	8,636	0	879	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	40,598	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	5,624	8,141	5,624	0	277	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	6,223	57,131	6,223	4,631	1,829	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	173,481	524,726	167,745	66,156	30,689	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,925	0	2,925	0	92	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	929	2,907	929	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	104	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	100	194.02
194.03	07953	UNUSED SPACE	2,807	0	2,807	0	0	194.03
194.04	07954	GUEST MEALS	0	0	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)	4,267,675	409,906	1,309,694	1,145,867	938,713	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.690616	0.776877	7.509455	17.320681	30.295724	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,954,204	78,131	124,110	285,138	144,850	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B-1 | Date/Time Prepared: 9/30/2013 9:23 am

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	10.848131	0.148078	0.711615	4.310085	4.674843	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B-1 | Date/Time Prepared: 9/30/2013 9:23 am

		Cost Center Description	NURSING ADMINISTRATION (NURSING WAGES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	10,570,771					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	106,085	5,543,273				14.00
15.00	01500	PHARMACY	0	13,175	2,132,951			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	14,392	0	377,331,698		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,852,554	220,459	0	27,459,523		30.00
31.00	03100	INTENSIVE CARE UNIT	1,519,701	129,613	0	11,994,081		31.00
40.00	04000	SUBPROVIDER - IPF	730,010	23,870	0	6,896,607		40.00
43.00	04300	NURSERY	229,178	819	0	1,516,984		43.00
44.00	04400	SKILLED NURSING FACILITY	0	114,442	0	4,770,056		44.00
45.00	04500	NURSING FACILITY	0	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,730,792	842,336	0	78,187,779		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	208,517	107,821	0	1,380,228		52.00
53.00	05300	ANESTHESIOLOGY	1,477,920	95,108	0	30,138,144		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	110,418	0	54,331,495		54.00
54.01	05401	ULTRASOUND	0	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	0	539,243	0	61,799,734		60.00
65.00	06500	RESPIRATORY THERAPY	0	75,962	0	5,888,922		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,879,554		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	490,089	15,854	0	10,582,783		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	886,923	0	11,347,674		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,155,808	0	15,662,292		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,132,951	21,146,955		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	505,455		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0		76.00
76.01	03561	SLEEP LAB	0	14,499	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0		76.02
76.03	03950	WOUND CARE	0	48,352	0	3,295,644		76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
91.00	09100	EMERGENCY	1,225,925	133,938	0	24,547,788		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
99.00	09900	CMHC	0	0	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,570,771	5,543,032	2,132,951	377,331,698		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	156	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.00
194.01	07951	MARKETING	0	85	0	0		194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0		194.02
194.03	07953	UNUSED SPACE	0	0	0	0		194.03
194.04	07954	GUEST MEALS	0	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)	2,228,449	1,156,430	1,316,274	1,493,048		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.210812	0.208619	0.617114	0.003957		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	188,450	319,636	131,942	321,491		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet B-1 | Date/Time Prepared: 9/30/2013 9:23 am

		Cost Center Description	NURSING ADMINISTRATION (NURSING WAGES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	0.017827	0.057662	0.061859	0.000852		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet C Part I Date/Time Prepared: 9/30/2013 9:23 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,089,750		8,089,750	0	8,089,750	30.00
31.00	03100	INTENSIVE CARE UNIT	3,327,865		3,327,865	0	3,327,865	31.00
40.00	04000	SUBPROVIDER - IPF	1,995,148		1,995,148	0	1,995,148	40.00
43.00	04300	NURSERY	526,956		526,956	0	526,956	43.00
44.00	04400	SKILLED NURSING FACILITY	3,596,434		3,596,434	0	3,596,434	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,094,337		6,094,337	0	6,094,337	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	503,874		503,874	0	503,874	52.00
53.00	05300	ANESTHESIOLOGY	2,869,902		2,869,902	0	2,869,902	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,613,944		4,613,944	0	4,613,944	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	4,241,237		4,241,237	0	4,241,237	60.00
65.00	06500	RESPIRATORY THERAPY	960,791	0	960,791	0	960,791	65.00
66.00	06600	PHYSICAL THERAPY	1,246,120	0	1,246,120	0	1,246,120	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	1,773,695		1,773,695	0	1,773,695	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,401,223		1,401,223	0	1,401,223	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,031,069		3,031,069	0	3,031,069	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,892,601		3,892,601	0	3,892,601	73.00
74.00	07400	RENAL DIALYSIS	183,243		183,243	0	183,243	74.00
76.00	03560	OTHER ANCILLARY COSTS	0		0	0	0	76.00
76.01	03561	SLEEP LAB	3,025		3,025	0	3,025	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0		0	0	0	76.02
76.03	03950	WOUND CARE	1,088,168		1,088,168	0	1,088,168	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
91.00	09100	EMERGENCY	3,100,186		3,100,186	0	3,100,186	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	629,451		629,451		629,451	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
99.00	09900	CMHC	0		0		0	99.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	53,169,019	0	53,169,019	0	53,169,019	200.00
201.00		Less Observation Beds	629,451		629,451		629,451	201.00
202.00		Total (see instructions)	52,539,568	0	52,539,568	0	52,539,568	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet C Part I | Date/Time Prepared: 9/30/2013 9:23 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,246,698		24,246,698			30.00
31.00	03100	INTENSIVE CARE UNIT	11,994,081		11,994,081			31.00
40.00	04000	SUBPROVIDER - IPF	6,896,607		6,896,607			40.00
43.00	04300	NURSERY	1,516,984		1,516,984			43.00
44.00	04400	SKILLED NURSING FACILITY	4,770,056		4,770,056			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,586,812	50,600,967	78,187,779	0.077945	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,276,750	103,478	1,380,228	0.365066	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	11,138,812	18,999,332	30,138,144	0.095225	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,153,266	43,178,229	54,331,495	0.084922	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	19,758,544	42,041,190	61,799,734	0.068629	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	5,095,790	793,132	5,888,922	0.163152	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,764,942	114,612	5,879,554	0.211941	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	3,209,827	7,372,956	10,582,783	0.167602	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,054,908	3,292,766	11,347,674	0.123481	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,039,610	6,622,682	15,662,292	0.193527	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,959,261	5,187,694	21,146,955	0.184074	0.000000	73.00
74.00	07400	RENAL DIALYSIS	505,455	0	505,455	0.362531	0.000000	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0.000000	0.000000	76.00
76.01	03561	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0.000000	0.000000	76.02
76.03	03950	WOUND CARE	0	3,295,644	3,295,644	0.330184	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
91.00	09100	EMERGENCY	4,273,316	20,274,472	24,547,788	0.126292	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	606,022	2,606,803	3,212,825	0.195918	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
99.00	09900	CMHC	0	0	0			99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	172,847,741	204,483,957	377,331,698			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	172,847,741	204,483,957	377,331,698			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet C Part I Date/Time Prepared: 9/30/2013 9:23 am

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
45.00	04500	NURSING FACILITY		45.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.077945	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.365066	52.00
53.00	05300	ANESTHESIOLOGY	0.095225	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084922	54.00
54.01	05401	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	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.068629	60.00
65.00	06500	RESPIRATORY THERAPY	0.163152	65.00
66.00	06600	PHYSICAL THERAPY	0.211941	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.167602	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.123481	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.193527	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.184074	73.00
74.00	07400	RENAL DIALYSIS	0.362531	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	76.00
76.01	03561	SLEEP LAB	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	76.02
76.03	03950	WOUND CARE	0.330184	76.03
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		89.00
91.00	09100	EMERGENCY	0.126292	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.195918	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
99.00	09900	CMHC		99.00
101.00	10100	HOME HEALTH AGENCY		101.00
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: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet C Part I Date/Time Prepared: 9/30/2013 9:23 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,089,750		8,089,750	0	8,089,750	30.00
31.00	03100	INTENSIVE CARE UNIT	3,327,865		3,327,865	0	3,327,865	31.00
40.00	04000	SUBPROVIDER - IPF	1,995,148		1,995,148	0	1,995,148	40.00
43.00	04300	NURSERY	526,956		526,956	0	526,956	43.00
44.00	04400	SKILLED NURSING FACILITY	3,596,434		3,596,434	0	3,596,434	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,094,337		6,094,337	0	6,094,337	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	503,874		503,874	0	503,874	52.00
53.00	05300	ANESTHESIOLOGY	2,869,902		2,869,902	0	2,869,902	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,613,944		4,613,944	0	4,613,944	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	4,241,237		4,241,237	0	4,241,237	60.00
65.00	06500	RESPIRATORY THERAPY	960,791	0	960,791	0	960,791	65.00
66.00	06600	PHYSICAL THERAPY	1,246,120	0	1,246,120	0	1,246,120	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	1,773,695		1,773,695	0	1,773,695	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,401,223		1,401,223	0	1,401,223	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,031,069		3,031,069	0	3,031,069	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,892,601		3,892,601	0	3,892,601	73.00
74.00	07400	RENAL DIALYSIS	183,243		183,243	0	183,243	74.00
76.00	03560	OTHER ANCILLARY COSTS	0		0	0	0	76.00
76.01	03561	SLEEP LAB	3,025		3,025	0	3,025	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0		0	0	0	76.02
76.03	03950	WOUND CARE	1,088,168		1,088,168	0	1,088,168	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
91.00	09100	EMERGENCY	3,100,186		3,100,186	0	3,100,186	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	629,451		629,451		629,451	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
99.00	09900	CMHC	0		0		0	99.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	53,169,019	0	53,169,019	0	53,169,019	200.00
201.00		Less Observation Beds	629,451		629,451		629,451	201.00
202.00		Total (see instructions)	52,539,568	0	52,539,568	0	52,539,568	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet C Part I Date/Time Prepared: 9/30/2013 9:23 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,246,698		24,246,698			30.00
31.00	03100	INTENSIVE CARE UNIT	11,994,081		11,994,081			31.00
40.00	04000	SUBPROVIDER - IPF	6,896,607		6,896,607			40.00
43.00	04300	NURSERY	1,516,984		1,516,984			43.00
44.00	04400	SKILLED NURSING FACILITY	4,770,056		4,770,056			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,586,812	50,600,967	78,187,779	0.077945	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,276,750	103,478	1,380,228	0.365066	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	11,138,812	18,999,332	30,138,144	0.095225	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,153,266	43,178,229	54,331,495	0.084922	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	19,758,544	42,041,190	61,799,734	0.068629	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	5,095,790	793,132	5,888,922	0.163152	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,764,942	114,612	5,879,554	0.211941	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	3,209,827	7,372,956	10,582,783	0.167602	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,054,908	3,292,766	11,347,674	0.123481	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,039,610	6,622,682	15,662,292	0.193527	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,959,261	5,187,694	21,146,955	0.184074	0.000000	73.00
74.00	07400	RENAL DIALYSIS	505,455	0	505,455	0.362531	0.000000	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0.000000	0.000000	76.00
76.01	03561	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0.000000	0.000000	76.02
76.03	03950	WOUND CARE	0	3,295,644	3,295,644	0.330184	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
91.00	09100	EMERGENCY	4,273,316	20,274,472	24,547,788	0.126292	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	606,022	2,606,803	3,212,825	0.195918	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
99.00	09900	CMHC	0	0	0			99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	172,847,741	204,483,957	377,331,698			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	172,847,741	204,483,957	377,331,698			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet C Part I Date/Time Prepared: 9/30/2013 9:23 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
45.00	04500	NURSING FACILITY		45.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.077945	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.365066	52.00
53.00	05300	ANESTHESIOLOGY	0.095225	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084922	54.00
54.01	05401	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	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.068629	60.00
65.00	06500	RESPIRATORY THERAPY	0.163152	65.00
66.00	06600	PHYSICAL THERAPY	0.211941	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.167602	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.123481	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.193527	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.184074	73.00
74.00	07400	RENAL DIALYSIS	0.362531	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	76.00
76.01	03561	SLEEP LAB	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	76.02
76.03	03950	WOUND CARE	0.330184	76.03
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	89.00
91.00	09100	EMERGENCY	0.126292	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.195918	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
99.00	09900	CMHC		99.00
101.00	10100	HOME HEALTH AGENCY		101.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet C Part II Date/Time Prepared: 9/30/2013 9:23 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,094,337	812,285	5,282,052	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	503,874	35,169	468,705	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,869,902	113,718	2,756,184	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,613,944	551,810	4,062,134	0	0	54.00
54.01	05401	ULTRASOUND	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	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	4,241,237	385,521	3,855,716	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	960,791	114,020	846,771	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,246,120	70,482	1,175,638	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	1,773,695	317,662	1,456,033	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,401,223	79,058	1,322,165	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,031,069	176,903	2,854,166	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,892,601	188,794	3,703,807	0	0	73.00
74.00	07400	RENAL DIALYSIS	183,243	8,775	174,468	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	3,025	836	2,189	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	1,088,168	199,391	888,777	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	3,100,186	321,687	2,778,499	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	629,451	113,083	516,368	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
200.00		Subtotal (sum of lines 50 thru 199)	35,632,866	3,489,194	32,143,672	0	0	200.00
201.00		Less Observation Beds	629,451	113,083	516,368	0	0	201.00
202.00		Total (line 200 minus line 201)	35,003,415	3,376,111	31,627,304	0	0	202.00

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

Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet C Part II Date/Time Prepared: 9/30/2013 9:23 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	6,094,337	78,187,779	0.077945		50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	503,874	1,380,228	0.365066		52.00
53.00	05300	ANESTHESIOLOGY	2,869,902	30,138,144	0.095225		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,613,944	54,331,495	0.084922		54.00
54.01	05401	ULTRASOUND	0	0	0.000000		54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000		56.00
57.00	05700	CT SCAN	0	0	0.000000		57.00
58.00	05800	MRI	0	0	0.000000		58.00
60.00	06000	LABORATORY	4,241,237	61,799,734	0.068629		60.00
65.00	06500	RESPIRATORY THERAPY	960,791	5,888,922	0.163152		65.00
66.00	06600	PHYSICAL THERAPY	1,246,120	5,879,554	0.211941		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	1,773,695	10,582,783	0.167602		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,401,223	11,347,674	0.123481		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,031,069	15,662,292	0.193527		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,892,601	21,146,955	0.184074		73.00
74.00	07400	RENAL DIALYSIS	183,243	505,455	0.362531		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000		76.00
76.01	03561	SLEEP LAB	3,025	0	0.000000		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000		76.02
76.03	03950	WOUND CARE	1,088,168	3,295,644	0.330184		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000		89.00
91.00	09100	EMERGENCY	3,100,186	24,547,788	0.126292		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	629,451	3,212,825	0.195918		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0.000000		95.00
99.00	09900	CMHC	0	0	0.000000		99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
200.00		Subtotal (sum of lines 50 thru 199)	35,632,866	327,907,272			200.00
201.00		Less Observation Beds	629,451	0			201.00
202.00		Total (line 200 minus line 201)	35,003,415	327,907,272			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part I Date/Time Prepared: 9/30/2013 9:23 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,453,357	0	1,453,357	11,811	123.05	30.00
31.00	INTENSIVE CARE UNIT	290,260		290,260	2,539	114.32	31.00
40.00	SUBPROVIDER - IPF	315,839	0	315,839	2,586	122.13	40.00
43.00	NURSERY	58,187		58,187	881	66.05	43.00
44.00	SKILLED NURSING FACILITY	618,008		618,008	7,581	81.52	44.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30-199)	2,735,651		2,735,651	25,398		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	7,202	886,206	30.00
31.00	INTENSIVE CARE UNIT	1,983	226,697	31.00
40.00	SUBPROVIDER - IPF	2,276	277,968	40.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	6,920	564,118	44.00
45.00	NURSING FACILITY	0	0	45.00
200.00	Total (lines 30-199)	18,381	1,954,989	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part II Date/Time Prepared: 9/30/2013 9:23 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	812,285	78,187,779	0.010389	17,639,278	183,254	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	35,169	1,380,228	0.025481	4,408	112	52.00
53.00	05300	ANESTHESIOLOGY	113,718	30,138,144	0.003773	6,915,179	26,091	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	551,810	54,331,495	0.010156	8,354,136	84,845	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	385,521	61,799,734	0.006238	12,141,027	75,736	60.00
65.00	06500	RESPIRATORY THERAPY	114,020	5,888,922	0.019362	2,956,273	57,239	65.00
66.00	06600	PHYSICAL THERAPY	70,482	5,879,554	0.011988	1,486,773	17,823	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	317,662	10,582,783	0.030017	2,467,041	74,053	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	79,058	11,347,674	0.006967	4,768,881	33,225	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	176,903	15,662,292	0.011295	6,519,042	73,633	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	188,794	21,146,955	0.008928	8,812,823	78,681	73.00
74.00	07400	RENAL DIALYSIS	8,775	505,455	0.017361	331,216	5,750	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0	0	76.00
76.01	03561	SLEEP LAB	836	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0	0	76.02
76.03	03950	WOUND CARE	199,391	3,295,644	0.060501	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100	EMERGENCY	321,687	24,547,788	0.013105	3,218,706	42,181	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	113,083	3,212,825	0.035197	450,833	15,868	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	3,489,194	327,907,272		76,065,616	768,491	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part III Date/Time Prepared: 9/30/2013 9:23 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
45.00	04500	NURSING FACILITY	0	0	0		0	45.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,811	0.00	7,202	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,539	0.00	1,983	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	2,586	0.00	2,276	0	0	40.00
43.00	04300	NURSERY	881	0.00	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	7,581	0.00	6,920	0	0	44.00
45.00	04500	NURSING FACILITY	0	0.00	0	0	0	45.00
200.00		Total (lines 30-199)	25,398		18,381	0	0	200.00

		Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost				
			12.00	13.00				
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0				30.00
31.00	03100	INTENSIVE CARE UNIT	0	0				31.00
40.00	04000	SUBPROVIDER - IPF	0	0				40.00
43.00	04300	NURSERY	0	0				43.00
44.00	04400	SKILLED NURSING FACILITY	0	0				44.00
45.00	04500	NURSING FACILITY	0	0				45.00
200.00		Total (lines 30-199)	0	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part IV | Date/Time Prepared: 9/30/2013 9:23 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						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: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part IV Date/Time Prepared: 9/30/2013 9:23 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	78,187,779	0.000000	0.000000	17,639,278	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,380,228	0.000000	0.000000	4,408	52.00
53.00	05300	ANESTHESIOLOGY	0	30,138,144	0.000000	0.000000	6,915,179	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54,331,495	0.000000	0.000000	8,354,136	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	61,799,734	0.000000	0.000000	12,141,027	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,888,922	0.000000	0.000000	2,956,273	65.00
66.00	06600	PHYSICAL THERAPY	0	5,879,554	0.000000	0.000000	1,486,773	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	10,582,783	0.000000	0.000000	2,467,041	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,347,674	0.000000	0.000000	4,768,881	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,662,292	0.000000	0.000000	6,519,042	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	21,146,955	0.000000	0.000000	8,812,823	73.00
74.00	07400	RENAL DIALYSIS	0	505,455	0.000000	0.000000	331,216	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0.000000	0	76.00
76.01	03561	SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0.000000	0	76.02
76.03	03950	WOUND CARE	0	3,295,644	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100	EMERGENCY	0	24,547,788	0.000000	0.000000	3,218,706	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,212,825	0.000000	0.000000	450,833	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	327,907,272			76,065,616	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part IV Date/Time Prepared: 9/30/2013 9:23 am

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	17,518,001	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	5,606,470	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,591,838	0	0	0	54.00
54.01	05401	ULTRASOUND	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	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	1,024,368	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,310,039	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	379	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	3,319,646	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,105,249	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,047,968	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,987,004	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	4,244,936	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	910,927	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	54,666,825	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part IV Date/Time Prepared: 9/30/2013 9:23 am

Title XVIII | Hospital | PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			23.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0		76.00
76.01	03561	SLEEP LAB	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
76.03	03950	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part V Date/Time Prepared: 9/30/2013 9:23 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.077945	17,518,001	0	0	1,365,441	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.365066	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.095225	5,606,470	0	0	533,876	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084922	14,591,838	0	0	1,239,168	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.068629	1,024,368	1,510	0	70,301	60.00
65.00	06500	RESPIRATORY THERAPY	0.163152	1,310,039	0	0	213,735	65.00
66.00	06600	PHYSICAL THERAPY	0.211941	379	0	0	80	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	0.167602	3,319,646	0	0	556,379	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.123481	1,105,249	0	0	136,477	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.193527	3,047,968	0	0	589,864	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.184074	1,987,004	1,039	0	365,756	73.00
74.00	07400	RENAL DIALYSIS	0.362531	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	0	0	76.00
76.01	03561	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03950	WOUND CARE	0.330184	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
91.00	09100	EMERGENCY	0.126292	4,244,936	0	0	536,101	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.195918	910,927	0	0	178,467	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		54,666,825	2,549	0	5,785,645	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		54,666,825	2,549	0	5,785,645	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part V Date/Time Prepared: 9/30/2013 9:23 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	104	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	191	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0		76.00
76.01	03561	SLEEP LAB	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
76.03	03950	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	295	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	295	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140040 | Component CCN: 14S040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part II Date/Time Prepared: 9/30/2013 9:23 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	812,285	78,187,779	0.010389	4,897	51	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	35,169	1,380,228	0.025481	0	0	52.00
53.00	05300	ANESTHESIOLOGY	113,718	30,138,144	0.003773	2,260	9	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	551,810	54,331,495	0.010156	342,385	3,477	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	385,521	61,799,734	0.006238	836,198	5,216	60.00
65.00	06500	RESPIRATORY THERAPY	114,020	5,888,922	0.019362	50,963	987	65.00
66.00	06600	PHYSICAL THERAPY	70,482	5,879,554	0.011988	160,370	1,923	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	317,662	10,582,783	0.030017	61,066	1,833	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	79,058	11,347,674	0.006967	6,387	44	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	176,903	15,662,292	0.011295	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	188,794	21,146,955	0.008928	614,729	5,488	73.00
74.00	07400	RENAL DIALYSIS	8,775	505,455	0.017361	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0	0	76.00
76.01	03561	SLEEP LAB	836	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0	0	76.02
76.03	03950	WOUND CARE	199,391	3,295,644	0.060501	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100	EMERGENCY	321,687	24,547,788	0.013105	166,885	2,187	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,212,825	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	3,376,111	327,907,272		2,246,140	21,215	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Component CCN: 14S040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part IV | Date/Time Prepared: 9/30/2013 9:23 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						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: 140040 | Component CCN: 14S040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part IV | Date/Time Prepared: 9/30/2013 9:23 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	78,187,779	0.000000	0.000000	4,897	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,380,228	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	30,138,144	0.000000	0.000000	2,260	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54,331,495	0.000000	0.000000	342,385	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	61,799,734	0.000000	0.000000	836,198	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,888,922	0.000000	0.000000	50,963	65.00
66.00	06600	PHYSICAL THERAPY	0	5,879,554	0.000000	0.000000	160,370	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	10,582,783	0.000000	0.000000	61,066	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,347,674	0.000000	0.000000	6,387	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,662,292	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	21,146,955	0.000000	0.000000	614,729	73.00
74.00	07400	RENAL DIALYSIS	0	505,455	0.000000	0.000000	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0.000000	0	76.00
76.01	03561	SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0.000000	0	76.02
76.03	03950	WOUND CARE	0	3,295,644	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100	EMERGENCY	0	24,547,788	0.000000	0.000000	166,885	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,212,825	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	327,907,272			2,246,140	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Component CCN: 14S040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part IV | Date/Time Prepared: 9/30/2013 9:23 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						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: 140040 | Component CCN: 14S040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part IV | Date/Time Prepared: 9/30/2013 9:23 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			23.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0		76.00
76.01	03561	SLEEP LAB	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
76.03	03950	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Component CCN: 145690 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part IV | Date/Time Prepared: 9/30/2013 9:23 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						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: 140040 | Component CCN: 145690 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part IV | Date/Time Prepared: 9/30/2013 9:23 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	78,187,779	0.000000	0.000000	13,657	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,380,228	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	30,138,144	0.000000	0.000000	8,482	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54,331,495	0.000000	0.000000	470,803	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	61,799,734	0.000000	0.000000	2,126,774	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,888,922	0.000000	0.000000	1,344,983	65.00
66.00	06600	PHYSICAL THERAPY	0	5,879,554	0.000000	0.000000	3,254,473	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	10,582,783	0.000000	0.000000	112,525	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,347,674	0.000000	0.000000	1,954,410	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,662,292	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	21,146,955	0.000000	0.000000	3,068,169	73.00
74.00	07400	RENAL DIALYSIS	0	505,455	0.000000	0.000000	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0.000000	0	76.00
76.01	03561	SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0.000000	0	76.02
76.03	03950	WOUND CARE	0	3,295,644	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100	EMERGENCY	0	24,547,788	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,212,825	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	327,907,272			12,354,276	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Component CCN: 145690 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part IV | Date/Time Prepared: 9/30/2013 9:23 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						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: 140040 | Component CCN: 145690 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part IV | Date/Time Prepared: 9/30/2013 9:23 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			23.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0		76.00
76.01	03561	SLEEP LAB	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
76.03	03950	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part I Date/Time Prepared: 9/30/2013 9:23 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,453,357	0	1,453,357	11,811	123.05	30.00
31.00	INTENSIVE CARE UNIT	290,260		290,260	2,539	114.32	31.00
40.00	SUBPROVIDER - IPF	315,839	0	315,839	2,586	122.13	40.00
43.00	NURSERY	58,187		58,187	881	66.05	43.00
44.00	SKILLED NURSING FACILITY	618,008		618,008	7,581	81.52	44.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30-199)	2,735,651		2,735,651	25,398		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	2,072	254,960				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
40.00	SUBPROVIDER - IPF	31	3,786				40.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
45.00	NURSING FACILITY	0	0				45.00
200.00	Total (lines 30-199)	2,103	258,746				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part II Date/Time Prepared: 9/30/2013 9:23 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	812,285	78,187,779	0.010389	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	35,169	1,380,228	0.025481	0	0	52.00
53.00	05300	ANESTHESIOLOGY	113,718	30,138,144	0.003773	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	551,810	54,331,495	0.010156	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	385,521	61,799,734	0.006238	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	114,020	5,888,922	0.019362	0	0	65.00
66.00	06600	PHYSICAL THERAPY	70,482	5,879,554	0.011988	0	0	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	317,662	10,582,783	0.030017	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	79,058	11,347,674	0.006967	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	176,903	15,662,292	0.011295	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	188,794	21,146,955	0.008928	0	0	73.00
74.00	07400	RENAL DIALYSIS	8,775	505,455	0.017361	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0	0	76.00
76.01	03561	SLEEP LAB	836	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0	0	76.02
76.03	03950	WOUND CARE	199,391	3,295,644	0.060501	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100	EMERGENCY	321,687	24,547,788	0.013105	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	113,083	3,212,825	0.035197	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	3,489,194	327,907,272		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part III Date/Time Prepared: 9/30/2013 9:23 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
45.00	04500	NURSING FACILITY	0	0	0		0	45.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,811	0.00	2,072	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,539	0.00	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	2,586	0.00	31	0	0	40.00
43.00	04300	NURSERY	881	0.00	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	7,581	0.00	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0.00	0	0	0	45.00
200.00		Total (lines 30-199)	25,398		2,103	0	0	200.00

		Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost		
			12.00	13.00		
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
43.00	04300	NURSERY	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
45.00	04500	NURSING FACILITY	0	0		45.00
200.00		Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part IV | Date/Time Prepared: 9/30/2013 9:23 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						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: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part IV Date/Time Prepared: 9/30/2013 9:23 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	78,187,779	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	1,380,228	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	30,138,144	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54,331,495	0.000000	0.000000	0	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	61,799,734	0.000000	0.000000	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,888,922	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5,879,554	0.000000	0.000000	0	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	10,582,783	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,347,674	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,662,292	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	21,146,955	0.000000	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	0	505,455	0.000000	0.000000	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0.000000	0	76.00
76.01	03561	SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0.000000	0	76.02
76.03	03950	WOUND CARE	0	3,295,644	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100	EMERGENCY	0	24,547,788	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,212,825	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	327,907,272			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part IV Date/Time Prepared: 9/30/2013 9:23 am

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						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: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D Part IV Date/Time Prepared: 9/30/2013 9:23 am

Title XIX | Hospital | PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			23.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0		76.00
76.01	03561	SLEEP LAB	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
76.03	03950	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (lines 50-199)	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D-1 | Date/Time Prepared: 9/30/2013 9:23 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	11,811	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,811	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.	1,159	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	9,733	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)	7,202	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,089,750	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)	8,089,750	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	24,246,698	28.00
29.00	Private room charges (excluding swing-bed charges)	2,861,291	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	21,385,407	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.333643	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	2,468.76	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	2,197.21	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	271.55	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	90.60	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	105,005	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	7,984,745	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	684.93	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,932,866	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)	4,932,866	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D-1 | Date/Time Prepared: 9/30/2013 9:23 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,327,865	2,539	1,310.70	1,983	2,599,118	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	8,876,177	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	16,408,161	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,112,903	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	768,491	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,881,394	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	14,526,767	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)	919	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	684.93	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	629,451	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D-1 | Date/Time Prepared: 9/30/2013 9:23 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,453,357	8,089,750	0.179654	629,451	113,083	90.00
91.00	Nursing School cost	0	8,089,750	0.000000	629,451	0	91.00
92.00	Allied health cost	0	8,089,750	0.000000	629,451	0	92.00
93.00	All other Medical Education	0	8,089,750	0.000000	629,451	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140040 Component CCN: 14S040	Period: From 05/01/2012 To 04/30/2013	Worksheet D-1 Date/Time Prepared: 9/30/2013 9:23 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,586	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,586	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)	2,586	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)	2,276	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,995,148	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)	1,995,148	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	6,896,607	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	6,896,607	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.289294	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)	2,666.90	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)	1,995,148	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	771.52	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,755,980	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)	1,755,980	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140040 | Component CCN: 14S040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D-1 | Date/Time Prepared: 9/30/2013 9:23 am

Title XVIII | Subprovider - IPF | 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	274,620	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,030,600	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)	277,968	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	21,215	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	299,183	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,731,417	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)	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: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D-1

Component CCN: 14S040 | Date/Time Prepared: 9/30/2013 9:23 am

Title XVIII | Subprovider - IPF | 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	315,839	1,995,148	0.158304	0	0	90.00
91.00	Nursing School cost	0	1,995,148	0.000000	0	0	91.00
92.00	Allied health cost	0	1,995,148	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,995,148	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140040 Component CCN: 145690	Period: From 05/01/2012 To 04/30/2013	Worksheet D-1 Date/Time Prepared: 9/30/2013 9:23 am
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,581	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,581	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.	82	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	7,499	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	6,920	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,596,434	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)	3,596,434	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	4,770,056	28.00
29.00	Private room charges (excluding swing-bed charges)	58,021	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	4,712,035	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.753961	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	707.57	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	628.36	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	79.21	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	59.72	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	4,897	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,591,537	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140040 | Component CCN: 145690 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D-1 | Date/Time Prepared: 9/30/2013 9:23 am

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)	3,591,537	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	473.76	71.00
72.00	Program routine service cost (line 9 x line 71)	3,278,419	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)	3,278,419	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)	3,278,419	83.00
84.00	Program inpatient ancillary services (see instructions)	1,921,967	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)	5,200,386	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: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D-1

Component CCN: 145690 | Date/Time Prepared: 9/30/2013 9:23 am

Title XVIII | Skilled Nursing Facility | PPS

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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D-1 | Date/Time Prepared: 9/30/2013 9:23 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	11,811	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,811	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	10,892	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)	2,072	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)	881	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,089,750	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)	8,089,750	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-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)	8,089,750	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	684.93	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,419,175	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)	1,419,175	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D-1 | Date/Time Prepared: 9/30/2013 9:23 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	526,956	881	598.13	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,327,865	2,539	1,310.70	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,419,175	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)	254,960	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	254,960	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,164,215	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)	919	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	684.93	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	629,451	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D-1 | Date/Time Prepared: 9/30/2013 9:23 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,453,357	8,089,750	0.179654	629,451	113,083	90.00
91.00	Nursing School cost	0	8,089,750	0.000000	629,451	0	91.00
92.00	Allied health cost	0	8,089,750	0.000000	629,451	0	92.00
93.00	All other Medical Education	0	8,089,750	0.000000	629,451	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D-3 | Date/Time Prepared: 9/30/2013 9:23 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		15,773,220		30.00
31.00	03100	INTENSIVE CARE UNIT		9,361,554		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.077945	17,639,278	1,374,894	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.365066	4,408	1,609	52.00
53.00	05300	ANESTHESIOLOGY	0.095225	6,915,179	658,498	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084922	8,354,136	709,450	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.068629	12,141,027	833,227	60.00
65.00	06500	RESPIRATORY THERAPY	0.163152	2,956,273	482,322	65.00
66.00	06600	PHYSICAL THERAPY	0.211941	1,486,773	315,108	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	0.167602	2,467,041	413,481	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.123481	4,768,881	588,866	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.193527	6,519,042	1,261,611	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.184074	8,812,823	1,622,212	73.00
74.00	07400	RENAL DIALYSIS	0.362531	331,216	120,076	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	76.00
76.01	03561	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	76.02
76.03	03950	WOUND CARE	0.330184	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	09100	EMERGENCY	0.126292	3,218,706	406,497	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.195918	450,833	88,326	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		76,065,616	8,876,177	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)		76,065,616		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140040 | Component CCN: 14S040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D-3 | Date/Time Prepared: 9/30/2013 9:23 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		6,019,526		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.077945	4,897	382	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.365066	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.095225	2,260	215	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084922	342,385	29,076	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.068629	836,198	57,387	60.00
65.00	06500	RESPIRATORY THERAPY	0.163152	50,963	8,315	65.00
66.00	06600	PHYSICAL THERAPY	0.211941	160,370	33,989	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	0.167602	61,066	10,235	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.123481	6,387	789	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.193527	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.184074	614,729	113,156	73.00
74.00	07400	RENAL DIALYSIS	0.362531	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	76.00
76.01	03561	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	76.02
76.03	03950	WOUND CARE	0.330184	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	09100	EMERGENCY	0.126292	166,885	21,076	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.195918	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		2,246,140	274,620	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)		2,246,140		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140040 | Component CCN: 145690 | Period: From 05/01/2012 To 04/30/2013 | Worksheet D-3 | Date/Time Prepared: 9/30/2013 9:23 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		4,354,148		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.077945	13,657	1,064	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.365066	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.095225	8,482	808	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084922	470,803	39,982	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.068629	2,126,774	145,958	60.00
65.00	06500	RESPIRATORY THERAPY	0.163152	1,344,983	219,437	65.00
66.00	06600	PHYSICAL THERAPY	0.211941	3,254,473	689,756	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	0.167602	112,525	18,859	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.123481	1,954,410	241,333	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.193527	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.184074	3,068,169	564,770	73.00
74.00	07400	RENAL DIALYSIS	0.362531	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	76.00
76.01	03561	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	76.02
76.03	03950	WOUND CARE	0.330184	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	09100	EMERGENCY	0.126292	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.195918	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		12,354,276	1,921,967	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)		12,354,276		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet E Part A Date/Time Prepared: 9/30/2013 9:23 am

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		MDH	Non MDH	
		1.00	1.01	
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS			
1.00	DRG Amounts Other than Outlier Payments	11,650,799	444,305	1.00
2.00	Outlier payments for discharges. (see instructions)	186,530	6,597	2.00
2.01	Outlier reconciliation amount	0	0	2.01
3.00	Managed Care Simulated Payments	0	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	93.48		4.00
	Indirect Medical Education Adjustment			
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.	0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00		11.00
12.00	Current year allowable FTE (see instructions)	0.00		12.00
13.00	Total allowable FTE count for the prior year.	0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00		15.00
16.00	Adjustment for residents in initial years of the program	0.00		16.00
17.00	Adjusment 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	0	22.00
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA			
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000		26.00
27.00	IME payments adjustment. (see instructions)	0.000000		27.00
28.00	IME Adjustment (see instructions)	0	0	28.00
29.00	Total IME payment (sum of lines 22 and 28)	0	0	29.00
	Disproportionate Share Adjustment			
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.99		30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)	15.53		31.00
32.00	Sum of lines 30 and 31	18.52		32.00
33.00	Allowable disproportionate share percentage (see instructions)	4.79	4.79	33.00
34.00	Disproportionate share adjustment (see instructions)	558,073	21,282	34.00
	Additional payment for high percentage of ESRD beneficiary discharges			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)	0		46.00
47.00	Subtotal (see instructions)	12,395,402	472,184	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	13,542,430	0	48.00

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		MDH	Non MDH	
		1.00	1.01	
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	13,727,857		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)	1,008,219		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)	0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).	0		52.00
53.00	Nursing and Allied Health Managed Care payment	0		53.00
54.00	Special add-on payments for new technologies	0		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)	0		55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)	0		56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).	0		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)	0		58.00
59.00	Total (sum of amounts on lines 49 through 58)	14,736,076		59.00
60.00	Primary payer payments	6,508		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	14,729,568		61.00
62.00	Deductibles billed to program beneficiaries	1,333,140		62.00
63.00	Coinsurance billed to program beneficiaries	55,815		63.00
64.00	Allowable bad debts (see instructions)	371,153		64.00
65.00	Adjusted reimbursable bad debts (see instructions)	259,807		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	312,675		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	13,600,420		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	SEQUESTRATION	-18,530		70.00
70.93	HVBP incentive payment (see instructions)	-60,612		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)	-3,937		70.94
70.95	Recovery of Accelerated Depreciation	0		70.95
70.96	Low Volume Payment-1	0		70.96
70.97	Low Volume Payment-2	0		70.97
70.98	Low Volume Payment-3	0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)	13,517,341		71.00
72.00	Interim payments	13,321,971		72.00
73.00	Tentative settlement (for contractor use only)	0		73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)	195,370		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	774,921		75.00
	TO BE COMPLETED BY CONTRACTOR			
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)	0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2	0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)	0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)	0		93.00
94.00	The rate used to calculate the Time Value of Money	0.00		94.00
95.00	Time Value of Money for operating expenses(see instructions)	0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)	0		96.00

CALCULATION OF DSH PAYMENT PERCENTAGE | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet DSH | Date/Time Prepared: 9/30/2013 9:23 am

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		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF THE DSH PAYMENT PERCENTAGE						
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	2.99	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	15.53	0.00			15.53	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	18.52	0.00			15.53	3.00
4.00	Provider Type * (urban, rural,SCH, RRC, pickle - If pickle worksheet NA)	MDH				MDH	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	93.48	0.00			93.48	5.00
6.00	Disproportionate Share Payment Percentage (transfer to Worksheet E, Part A, line 33)	4.79	0.00			0.00	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No				No	9.00
10.00	S-2, Line 45	No				No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 geater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
	CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS						
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	2,220	0			2,220	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	0	0			0	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	3	0			3	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	2,223	0			2,223	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	14,312	0			14,312	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	14,312	0			14,312	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	15.53	0.00			15.53	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet DSH | Date/Time Prepared: 9/30/2013 9:23 am

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		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE						
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	False	0.00		0.00	False	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	True	4.79		0.00	True	29.00
30.00	Line 28 or 29 as applicable		4.79		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		0.00		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
	DETERMINATION OF PROVIDER TYPE						
32.00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	True				True	34.00
35.00	Is this a Sole Cummunity hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Rural				Rural	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet DSH | Date/Time Prepared: 9/30/2013 9:23 am

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		Revised Percentage 6.00		
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	0.00		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	2.84		29.00
30.00	Line 28 or 29 as applicable	2.84		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	0.00		31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet E Part B Date/Time Prepared: 9/30/2013 9:23 am

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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	295	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	5,785,645	2.00
3.00	PPS payments	5,700,162	3.00
4.00	Outlier payment (see instructions)	0	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)	295	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	2,549	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)	2,549	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	2,549	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	2,254	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)	295	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	5,700,162	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	1,255	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,308,216	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	4,390,986	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	4,390,986	30.00
31.00	Primary payer payments	1,122	31.00
32.00	Subtotal (line 30 minus line 31)	4,389,864	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	268,693	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	188,085	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	245,909	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	4,577,949	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.98	AB Re-billing demo amount (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	4,577,949	40.00
41.00	Interim payments	4,582,704	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)	-4,755	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00
		Overrides 1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet E-1 Part I | Date/Time Prepared: 9/30/2013 9:23 am

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		13,106,882		4,389,569	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		215,089		192,992	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	04/30/2013	143	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		143	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		13,321,971		4,582,704	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		195,370		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		4,755	6.02
7.00	Total Medicare program liability (see instructions)		13,517,341		4,577,949	7.00

			Contractor Number	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: 140040 | Component CCN: 14S040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet E-1 Part I | Date/Time Prepared: 9/30/2013 9:23 am

Title XVIII | Subprovider - IPF | 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		1,895,643		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		16,100		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)		1,911,743		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		5,069		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,916,812		0	7.00

			Contractor Number	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: 140040 | Component CCN: 145690 | Period: From 05/01/2012 To 04/30/2013 | Worksheet E-1 Part I | Date/Time Prepared: 9/30/2013 9:23 am

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,140,118		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)		2,140,118		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		999		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,141,117		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 140040	Period: From 05/01/2012 To 04/30/2013	Worksheet E-1 Part II Date/Time Prepared: 9/30/2013 9:23 am
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	3,054	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	9,185	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	1,167	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	13,431	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	377,331,698	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	1,152,758	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)	0	8.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)	0	32.00
		Overrides	
		1.00	
	CONTRACTOR OVERRIDES		
108.00	Override of HIT payment	0	108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140040 Component CCN: 14S040	Period: From 05/01/2012 To 04/30/2013	Worksheet E-3 Part II Date/Time Prepared: 9/30/2013 9:23 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	2,008,278	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	7.084932	9.00
10.00	Medical Education Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Medical Education Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2,008,278	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition	0	14.00
15.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	15.00
16.00	Subtotal (see instructions)	2,008,278	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	2,008,278	18.00
19.00	Deductibles	108,180	19.00
20.00	Subtotal (line 18 minus line 19)	1,900,098	20.00
21.00	Coinsurance	2,023	21.00
22.00	Subtotal (line 20 minus line 21)	1,898,075	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	30,242	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	21,169	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	23,610	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,919,244	26.00
27.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	SEQUESTRATION	-2,432	30.00
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,916,812	31.00
32.00	Interim payments	1,911,743	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus the sum lines 32 and 33)	5,069	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140040 Component CCN: 145690	Period: From 05/01/2012 To 04/30/2013	Worksheet E-3 Part VI Date/Time Prepared: 9/30/2013 9:23 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	2,358,742	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,358,742	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	214,771	7.00
8.00	Allowable bad debts (see instructions)	1,429	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Allowable reimbursable bad debts (see instructions)	1,000	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)	2,144,971	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	SEQUESTRATION	-3,854	14.00
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14	2,141,117	15.00
16.00	Interim payments	2,140,118	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus the sum of lines 16 and 17)	999	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: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet G | Date/Time Prepared: 9/30/2013 9:23 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-204,240	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	9,326,872	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-987,010	0	0	0	6.00
7.00	Inventory	1,823,180	0	0	0	7.00
8.00	Prepaid expenses	329,333	0	0	0	8.00
9.00	Other current assets	-1,543,791	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)	8,744,344	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	433,029	0	0	0	12.00
13.00	Land improvements	551,760	0	0	0	13.00
14.00	Accumulated depreciation	-297,140	0	0	0	14.00
15.00	Buildings	15,624,331	0	0	0	15.00
16.00	Accumulated depreciation	-4,531,910	0	0	0	16.00
17.00	Leasehold improvements	8,596,073	0	0	0	17.00
18.00	Accumulated depreciation	-2,352,278	0	0	0	18.00
19.00	Fixed equipment	2,349,641	0	0	0	19.00
20.00	Accumulated depreciation	-581,309	0	0	0	20.00
21.00	Automobiles and trucks	31,608	0	0	0	21.00
22.00	Accumulated depreciation	-13,386	0	0	0	22.00
23.00	Major movable equipment	10,869,666	0	0	0	23.00
24.00	Accumulated depreciation	-6,305,312	0	0	0	24.00
25.00	Minor equipment depreciable	4,839,016	0	0	0	25.00
26.00	Accumulated depreciation	-2,854,160	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	26,359,629	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,726,675	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,726,675	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	37,830,648	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,746,126	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,754,603	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	11,112	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	-89,090,434	0	0	0	43.00
44.00	Other current liabilities	1,103,546	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-83,475,047	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	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 liabilites (sum of lines 45 and 50)	-83,475,047	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	121,305,695				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	121,305,695	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	37,830,648	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet G-1 | Date/Time Prepared: 9/30/2013 9:23 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		102,297,164		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		19,008,531				2.00
3.00	Total (sum of line 1 and line 2)		121,305,695		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)		121,305,695		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)		121,305,695		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: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet G-2 Parts I & II | Date/Time Prepared: 9/30/2013 9:23 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	25,763,672		25,763,672	1.00
2.00	SUBPROVIDER - IPF	6,896,607		6,896,607	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	4,770,056		4,770,056	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	37,430,335		37,430,335	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	11,994,081		11,994,081	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)	11,994,081		11,994,081	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	49,424,416		49,424,416	17.00
18.00	Ancillary services	123,422,102	0	123,422,102	18.00
19.00	Outpatient services	0	204,485,180	204,485,180	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		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC		0	0	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)	172,846,518	204,485,180	377,331,698	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		61,439,371		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)		61,439,371		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet G-3 | Date/Time Prepared: 9/30/2013 9:23 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	377,331,698	1.00
2.00	Less contractual allowances and discounts on patients' accounts	298,977,586	2.00
3.00	Net patient revenues (line 1 minus line 2)	78,354,112	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	61,439,371	4.00
5.00	Net income from service to patients (line 3 minus line 4)	16,914,741	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	2,530,402	24.00
25.00	Total other income (sum of lines 6-24)	2,530,402	25.00
26.00	Total (line 5 plus line 25)	19,445,143	26.00
27.00	OTHER EXPENSES (SPECIFY)	436,612	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	436,612	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	19,008,531	29.00

CALCULATION OF CAPITAL PAYMENT | Provider CCN: 140040 | Period: From 05/01/2012 To 04/30/2013 | Worksheet L Parts I-III Date/Time Prepared: 9/30/2013 9:23 am

Title XVIII | Hospital | PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	960,751	1.00
2.00	Capital DRG outlier payments	47,468	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	36.80	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 reported on Worksheet S-3, Part I (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)	1,008,219	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00