

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED  
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 150075	Period: From 10/01/2011 To 09/30/2012	Worksheet S Parts I-III Date/Time Prepared: 2/27/2013 4:08 pm
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<b>PART I - COST REPORT STATUS</b>			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 2/27/2013	Time: 4:08 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by BLUFFTON REGIONAL MEDICAL CENTER ( 150075 ) for the cost reporting period beginning 10/01/2011 and ending 09/30/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) \_\_\_\_\_  
 Officer or Administrator of Provider(s)

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

Cost Center Description	Title XVIII			HIT	Title XIX	
	Title V	Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	-56,672	-41,016	-112,000	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
8.00 NURSING FACILITY	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	-56,672	-41,016	-112,000	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150075			Period: From 10/01/2011 To 09/30/2012		Worksheet S-2 Part I Date/Time Prepared: 2/27/2013 3:50 pm			
1.00 Hospital and Hospital Health Care Complex Address:		2.00		3.00		4.00				
1.00	Street: 303 S. MAIN STREET	PO Box:		Zip Code: 46714-		County: WELLS				
2.00	City: BLUFFTON	State: IN								
Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00		
V		XVIII		XIX						
3.00	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	BLUFFTON REGIONAL MEDICAL CENTER	150075	23060	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	BLUFFTON SKILLED NURSING	155373	23060		03/13/1991	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) 1									17.00
17.10	Hospital-Based (CORF) 1									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					10/01/2011	09/30/2012		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 days	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	690	0	0	0	757	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0		25.00	
						Urban/Rural S	Date of Geogr			
						1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1				26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1				27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0				35.00
						Beginning:	Ending:			
						1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.									36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.					0				37.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150075	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part I Date/Time Prepared: 2/27/2013 3:50 pm		
		Beginning:	Ending:			
		1.00	2.00			
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V	XVIII	XIX		
		1.00	2.00	3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	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		
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
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	
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>						
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		
64.00	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. 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		
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	
		1.00	2.00	3.00	4.00	
				Ratio (col. 3/ (col. 3 + col. 4))		
				5.00		

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150075	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part I Date/Time Prepared: 2/27/2013 3:50 pm			
		1.00	2.00	3.00			
<b>Inpatient Rehabilitation Facility PPS</b>							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N				75.00	
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		76.00	
		1.00					
<b>Long Term Care Hospital PPS</b>							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N					80.00
<b>TEFRA Providers</b>							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N					85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(i)? Enter "Y" for yes and "N" for no.						86.00
		V		XIX			
		1.00		2.00			
<b>Title V or XIX Inpatient Services</b>							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N		91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00	
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N		93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00			0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00			0.00	97.00	
<b>Rural Providers</b>							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N					105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)						106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)						107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N					108.00
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				N	109.00	
		1.00		2.00		3.00	
<b>Miscellaneous Cost Reporting Information</b>							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N					116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N					117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1					118.00
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	86,838	3,686			0	
		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

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		1.00	2.00			
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		
<b>Transplant Center Information</b>						
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		
<b>All Providers</b>						
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: CHS / COMMUNITY HEALTH SYSTEMS, INC.	Contractor's Name: WPS		Contractor's Number: 52280		141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:				142.00
143.00	City: FRANKLIN	State: TN		Zip Code: 37067		143.00
				1.00		
144.00	Are provider based physicians' costs included in Worksheet A?		Y	144.00		
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		N	145.00		
				1.00		
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	
156.00	Subprovider - IPF	N	N	N	N	
157.00	Subprovider - IRF	N	N	N	N	
158.00	SUBPROVIDER					
159.00	SNF	N	N	N	N	
160.00	HOME HEALTH AGENCY	N	N	N	N	
161.00	CMHC		N	N	N	
161.10	CORF		N	N	N	
				1.00		
<b>Multi campus</b>						
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00
		Name	County	State	Zip Code	CBSA
		0	1.00	2.00	3.00	4.00
				5.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet S-2  
Part I  
Date/Time Prepared:  
2/27/2013 3:50 pm

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						2,756,284	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: 150075	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part II Date/Time Prepared: 2/27/2013 3:50 pm
		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
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	Type	Date
		1.00	2.00	3.00
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	Legal Oper.	
		1.00	2.00	
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		
		Description	Y/N	Date
		0	1.00	2.00
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	01/24/2013	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)	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		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		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		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150075	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part II Date/Time Prepared: 2/27/2013 3:50 pm
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		Part A		
Description		Y/N	Date	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
		1.00	2.00	
		1.00		
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>				
<b>Capital Related Cost</b>				
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions	N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	Y		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		27.00
<b>Interest Expense</b>				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
<b>Purchased Services</b>				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N		33.00
<b>Provider-Based Physicians</b>				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	N		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N		35.00
		Y/N	Date	
		1.00	2.00	
<b>Home Office Costs</b>				
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	12/31/2011	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	
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RYAN	NELSON	41.00
42.00	Enter the employer/company name of the cost report preparer.	CHS/COMMUNITY HEALTH SYSTEMS, INC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(615) 465-7553	RYAN_NELSON@CHS.NET	43.00

		Part B		
		Y/N	Date	
		3.00	4.00	
<b>PS&amp;R Data</b>				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	01/24/2013	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)	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		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		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		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
		3.00		
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER, REVENUE MANAGEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/27/2013 3:50 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	
	Line Number				
	1.00	2.00	3.00	4.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	55	20,130	0.00	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					5.00
6.00 Hospital Adults & Peds. Swing Bed NF					6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		55	20,130	0.00	7.00
8.00 INTENSIVE CARE UNIT	31.00	7	2,562	0.00	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				13.00
14.00 Total (see instructions)		62	22,692	0.00	14.00
15.00 CAH visits					15.00
16.00 SUBPROVIDER - IPF					16.00
17.00 SUBPROVIDER - IRF					17.00
18.00 SUBPROVIDER					18.00
19.00 SKILLED NURSING FACILITY	44.00	13	4,758		19.00
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE					21.00
22.00 HOME HEALTH AGENCY					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00 HOSPICE					24.00
25.00 CMHC - CMHC					25.00
25.10 CMHC - CORF	99.10				25.10
26.00 RURAL HEALTH CLINIC	88.00				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				26.25
27.00 Total (sum of lines 14-26)		75			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 AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/27/2013 3:50 pm

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	3,331	536	6,961		1.00
2.00 HMO		1,200	757			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	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	3,331	536	6,961		7.00
8.00 INTENSIVE CARE UNIT	0	416	21	835		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		133	570		13.00
14.00 Total (see instructions)	0	3,747	690	8,366		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0	1,954	0	2,957		19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0		25.10
26.00 RURAL HEALTH CLINIC	0	0	0	0		26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	995		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: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/27/2013 3:50 pm

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	900	1.00
2.00 HMO					275	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	260.70	0.00	0	900	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00	11.27	0.00			19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00	0.00	0.00			25.10
26.00 RURAL HEALTH CLINIC	0.00	0.00	0.00			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00 Total (sum of lines 14-26)	0.00	271.97	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 AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/27/2013 3:50 pm

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	266	2,005		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				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)	266	2,005		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER				18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
25.10 CMHC - CORF				25.10
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				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: 150075	Period: From 10/01/2011 To 09/30/2012	Worksheet S-3 Part II Date/Time Prepared: 2/27/2013 3:50 pm
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	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
	1.00	2.00	3.00	4.00	5.00	
<b>PART II - WAGE DATA</b>						
<b>SALARIES</b>						
1.00	Total salaries (see instructions)	200.00	13,758,200	0	13,758,200	565,750.00 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00 2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00 3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00 4.01
5.00	Physician-Part B		0	0	0	0.00 5.00
6.00	Non-physician-Part B		0	0	0	0.00 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00 7.01
8.00	Home office personnel		0	0	0	0.00 8.00
9.00	SNF	44.00	507,288	0	507,288	23,447.00 9.00
10.00	Excluded area salaries (see instructions)		7,837	356,699	364,536	13,173.00 10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>						
11.00	Contract labor (see instructions)		129,747	0	129,747	995.00 11.00
12.00	Contract management and administrative services		0	0	0	0.00 12.00
13.00	Contract labor: Physician-Part A - Administrative		160,140	0	160,140	1,156.00 13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00 14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00 15.00
16.00	Home office and Contract Physicians Part A - Administrative		0	0	0	0.00 16.00
<b>WAGE-RELATED COSTS</b>						
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24		2,910,234	0	2,910,234	
18.00	Wage-related costs (other)Wkst S-3, Part IV Line 25		0	0	0	
19.00	Excluded areas		196,891	0	196,891	
20.00	Non-physician anesthetist Part A		0	0	0	
21.00	Non-physician anesthetist Part B		0	0	0	
22.00	Physician Part A - Administrative		0	0	0	
22.01	Physician Part A - Teaching		0	0	0	
23.00	Physician Part B		0	0	0	
24.00	Wage-related costs (RHC/FQHC)		0	0	0	
25.00	Interns & residents (in an approved program)		0	0	0	
<b>OVERHEAD COSTS - DIRECT SALARIES</b>						
26.00	Employee Benefits	4.00	133,120	70,613	203,733	6,802.00 26.00
27.00	Administrative & General	5.00	2,466,493	-328,605	2,137,888	95,974.00 27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00 28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00 29.00
30.00	Operation of Plant	7.00	519,175	0	519,175	23,502.00 30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00 31.00
32.00	Housekeeping	9.00	349,849	0	349,849	29,134.00 32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00 33.00
34.00	Dietary	10.00	460,032	-230,378	229,654	17,480.95 34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00 35.00
36.00	Cafeteria	11.00	0	230,378	230,378	17,536.05 36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00 37.00
38.00	Nursing Administration	13.00	883,668	144,724	1,028,392	26,280.00 38.00
39.00	Central Services and Supply	14.00	146,517	0	146,517	6,832.00 39.00
40.00	Pharmacy	15.00	547,943	0	547,943	15,444.00 40.00
41.00	Medical Records & Medical Records Library	16.00	455,472	0	455,472	24,280.00 41.00
42.00	Social Service	17.00	0	0	0	0.00 42.00
43.00	Other General Service	18.00	0	0	0	0.00 43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet S-3  
Part II  
Date/Time Prepared:  
2/27/2013 3:50 pm

		Average Hourly Wage (col. 4 ÷ col. 5)	
		6.00	
<b>PART II - WAGE DATA</b>			
<b>SALARIES</b>			
1.00	Total salaries (see instructions)	24.32	1.00
2.00	Non-physician anesthetist Part A	0.00	2.00
3.00	Non-physician anesthetist Part B	0.00	3.00
4.00	Physician-Part A - Administrative	0.00	4.00
4.01	Physicians - Part A - Teaching	0.00	4.01
5.00	Physician-Part B	0.00	5.00
6.00	Non-physician-Part B	0.00	6.00
7.00	Interns & residents (in an approved program)	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)	0.00	7.01
8.00	Home office personnel	0.00	8.00
9.00	SNF	21.64	9.00
10.00	Excluded area salaries (see instructions)	27.67	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>			
11.00	Contract labor (see instructions)	130.40	11.00
12.00	Contract management and administrative services	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative	138.53	13.00
14.00	Home office salaries & wage-related costs	0.00	14.00
15.00	Home office: Physician Part A - Administrative	0.00	15.00
16.00	Home office and Contract Physicians Part A - Administrative	0.00	16.00
<b>WAGE-RELATED COSTS</b>			
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24		17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV Line 25		18.00
19.00	Excluded areas		19.00
20.00	Non-physician anesthetist Part A		20.00
21.00	Non-physician anesthetist Part B		21.00
22.00	Physician Part A - Administrative		22.00
22.01	Physician Part A - Teaching		22.01
23.00	Physician Part B		23.00
24.00	Wage-related costs (RHC/FQHC)		24.00
25.00	Interns & residents (in an approved program)		25.00
<b>OVERHEAD COSTS - DIRECT SALARIES</b>			
26.00	Employee Benefits	29.95	26.00
27.00	Administrative & General	22.28	27.00
28.00	Administrative & General under contract (see inst.)	0.00	28.00
29.00	Maintenance & Repairs	0.00	29.00
30.00	Operation of Plant	22.09	30.00
31.00	Laundry & Linen Service	0.00	31.00
32.00	Housekeeping	12.01	32.00
33.00	Housekeeping under contract (see instructions)	0.00	33.00
34.00	Dietary	13.14	34.00
35.00	Dietary under contract (see instructions)	0.00	35.00
36.00	Cafeteria	13.14	36.00
37.00	Maintenance of Personnel	0.00	37.00
38.00	Nursing Administration	39.13	38.00
39.00	Central Services and Supply	21.45	39.00
40.00	Pharmacy	35.48	40.00
41.00	Medical Records & Medical Records Library	18.76	41.00
42.00	Social Service	0.00	42.00
43.00	Other General Service	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet S-3  
Part III  
Date/Time Prepared:  
2/27/2013 3:50 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>						
1.00	Net salaries (see instructions)	13,758,200	0	13,758,200	565,750.00	1.00
2.00	Excluded area salaries (see instructions)	515,125	356,699	871,824	36,620.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	13,243,075	-356,699	12,886,376	529,130.00	3.00
4.00	Subtotal other wages & related costs (see inst.)	289,887	0	289,887	2,151.00	4.00
5.00	Subtotal wage-related costs (see inst.)	2,910,234	0	2,910,234	0.00	5.00
6.00	Total (sum of lines 3 thru 5)	16,443,196	-356,699	16,086,497	531,281.00	6.00
7.00	Total overhead cost (see instructions)	5,962,269	-113,268	5,849,001	263,265.00	7.00

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 150075	Period: From 10/01/2011 To 09/30/2012	Worksheet S-3 Part III Date/Time Prepared: 2/27/2013 3:50 pm
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		Average Hourly Wage (col. 4 ÷ col. 5)	
		6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>			
1.00	Net salaries (see instructions)	24.32	1.00
2.00	Excluded area salaries (see instructions)	23.81	2.00
3.00	Subtotal salaries (line 1 minus line 2)	24.35	3.00
4.00	Subtotal other wages & related costs (see inst.)	134.77	4.00
5.00	Subtotal wage-related costs (see inst.)	22.58	5.00
6.00	Total (sum of lines 3 thru 5)	30.28	6.00
7.00	Total overhead cost (see instructions)	22.22	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150075	Period: From 10/01/2011 To 09/30/2012	Worksheet S-3 Part IV Date/Time Prepared: 2/27/2013 3:50 pm
			Amount Reported	
			1.00	
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions		365,684	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration Fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)		1,461,103	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		27,848	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		8,599	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		16,634	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		152,829	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
<b>TAXES</b>				
17.00	FICA-Employers Portion Only		790,560	17.00
18.00	Medicare Taxes - Employers Portion Only		184,889	18.00
19.00	Unemployment Insurance		44,561	19.00
20.00	State or Federal Unemployment Taxes		54,419	20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		3,107,126	24.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet S-3  
Part V  
Date/Time Prepared:  
2/27/2013 3:50 pm

Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet S-7

Date/Time Prepared:  
2/27/2013 3:50 pm

		1.00	2.00	3.00
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N		2.00

	Group	SNF Days	Swing Bed Days	Total (sum of col. 2 + 3)	
				1.00	2.00
3.00	RUX	0	0	0	3.00
4.00	RUL	0	0	0	4.00
5.00	RVX	0	0	0	5.00
6.00	RVL	0	0	0	6.00
7.00	RHX	0	0	0	7.00
8.00	RHL	14	0	14	8.00
9.00	RMX	0	0	0	9.00
10.00	RML	0	0	0	10.00
11.00	RLX	0	0	0	11.00
12.00	RUC	0	0	0	12.00
13.00	RUB	0	0	0	13.00
14.00	RUA	0	0	0	14.00
15.00	RVC	188	0	188	15.00
16.00	RVB	67	0	67	16.00
17.00	RVA	120	0	120	17.00
18.00	RHC	186	0	186	18.00
19.00	RHB	246	0	246	19.00
20.00	RHA	408	0	408	20.00
21.00	RMC	101	0	101	21.00
22.00	RMB	24	0	24	22.00
23.00	RMA	361	0	361	23.00
24.00	RLB	0	0	0	24.00
25.00	RLA	0	0	0	25.00
26.00	ES3	0	0	0	26.00
27.00	ES2	0	0	0	27.00
28.00	ES1	0	0	0	28.00
29.00	HE2	0	0	0	29.00
30.00	HE1	0	0	0	30.00
31.00	HD2	0	0	0	31.00
32.00	HD1	8	0	8	32.00
33.00	HC2	0	0	0	33.00
34.00	HC1	0	0	0	34.00
35.00	HB2	0	0	0	35.00
36.00	HB1	37	0	37	36.00
37.00	LE2	0	0	0	37.00
38.00	LE1	0	0	0	38.00
39.00	LD2	0	0	0	39.00
40.00	LD1	0	0	0	40.00
41.00	LC2	0	0	0	41.00
42.00	LC1	8	0	8	42.00
43.00	LB2	0	0	0	43.00
44.00	LB1	5	0	5	44.00
45.00	CE2	0	0	0	45.00
46.00	CE1	1	0	1	46.00
47.00	CD2	0	0	0	47.00
48.00	CD1	3	0	3	48.00
49.00	CC2	0	0	0	49.00
50.00	CC1	18	0	18	50.00
51.00	CB2	0	0	0	51.00
52.00	CB1	82	0	82	52.00
53.00	CA2	0	0	0	53.00
54.00	CA1	70	0	70	54.00
55.00	SE3	0	0	0	55.00
56.00	SE2	0	0	0	56.00
57.00	SE1	0	0	0	57.00
58.00	SSC	0	0	0	58.00
59.00	SSB	0	0	0	59.00
60.00	SSA	0	0	0	60.00
61.00	IB2	0	0	0	61.00
62.00	IB1	0	0	0	62.00
63.00	IA2	0	0	0	63.00
64.00	IA1	0	0	0	64.00
65.00	BB2	0	0	0	65.00
66.00	BB1	1	0	1	66.00
67.00	BA2	0	0	0	67.00
68.00	BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet S-7

Date/Time Prepared:  
2/27/2013 3:50 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	5	0	5	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	1	0	1	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		1,954	0	1,954	200.00

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

201.00	SNF SERVICES	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	23060	23060	201.00
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		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)					
202.00	Staffing		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)		1,976,995		207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150075	Period: From 10/01/2011 To 09/30/2012	Worksheet S-10 Date/Time Prepared: 2/27/2013 3:50 pm
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			1.00		
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.207777	1.00	
<b>Medicaid (see instructions for each line)</b>					
2.00	Net revenue from Medicaid		1,507,176	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		476,441	5.00	
6.00	Medicaid charges		15,703,123	6.00	
7.00	Medicaid cost (line 1 times line 6)		3,262,748	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		1,279,131	8.00	
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>					
9.00	Net revenue from stand-alone SCHIP		213,615	9.00	
10.00	Stand-alone SCHIP charges		983,359	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		204,319	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
<b>Other state or local government indigent care program (see instructions for each line)</b>					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		208,870	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		1,579,977	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		328,283	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)		119,413	16.00	
<b>Uncompensated care (see instructions for each line)</b>					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		1,398,544	19.00	
			1.00		
			2.00		
			3.00		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	308,174	0	308,174	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	64,031	0	64,031	21.00
22.00	Partial payment by patients approved for charity care	35,946	0	35,946	22.00
23.00	Cost of charity care (line 21 minus line 22)	28,085	0	28,085	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)		2,988,742	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		19,032	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		2,969,710	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		617,037	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		645,122	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,043,666	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A

Date/Time Prepared:  
2/27/2013 3:50 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		1,537,158	1,537,158	445,880	1,983,038	1.00
1.01	00101		0	0	0	0	1.01
2.00	00200		1,960,141	1,960,141	345,351	2,305,492	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	133,120	37,420	170,540	2,195,568	2,366,108	4.00
5.01	00510	0	0	0	511,335	511,335	5.01
5.02	00540	0	0	0	377,724	377,724	5.02
5.03	00550	0	0	0	5,576,886	5,576,886	5.03
5.04	00560	2,466,493	14,575,544	17,042,037	-9,709,536	7,332,501	5.04
7.00	00700	519,175	1,486,706	2,005,881	-1,105	2,004,776	7.00
8.00	00800	0	179,336	179,336	0	179,336	8.00
9.00	00900	349,849	219,767	569,616	0	569,616	9.00
10.00	01000	460,032	334,833	794,865	-398,870	395,995	10.00
11.00	01100	0	0	0	397,243	397,243	11.00
13.00	01300	883,668	195,870	1,079,538	130,036	1,209,574	13.00
14.00	01400	146,517	1,097,177	1,243,694	-636,984	606,710	14.00
15.00	01500	547,943	1,399,998	1,947,941	-1,222,928	725,013	15.00
16.00	01600	455,472	187,455	642,927	-7,170	635,757	16.00
17.00	01700	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	2,090,130	1,409,563	3,499,693	-393,159	3,106,534	30.00
31.00	03100	617,297	84,537	701,834	-1,411	700,423	31.00
43.00	04300	0	0	0	219,841	219,841	43.00
44.00	04400	507,288	87,969	595,257	-907	594,350	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	628,192	255,345	883,537	414,565	1,298,102	50.00
51.00	05100	323,985	69,119	393,104	-393,104	0	51.00
52.00	05200	0	0	0	145,721	145,721	52.00
53.00	05300	0	626,304	626,304	-41,763	584,541	53.00
54.00	05400	618,722	207,735	826,457	220,324	1,046,781	54.00
54.01	03630	105,780	13,094	118,874	-118,874	0	54.01
56.00	05600	60,190	82,061	142,251	0	142,251	56.00
57.00	05700	85,746	49,167	134,913	-134,913	0	57.00
58.00	05800	105,230	12,422	117,652	-117,652	0	58.00
60.00	06000	837,767	699,046	1,536,813	-356,695	1,180,118	60.00
65.00	06500	380,262	68,598	448,860	-2,014	446,846	65.00
66.00	06600	422,612	63,397	486,009	266,820	752,829	66.00
67.00	06700	174,107	17,331	191,438	-191,438	0	67.00
68.00	06800	69,588	8,570	78,158	-78,158	0	68.00
69.00	06900	43,687	92,290	135,977	0	135,977	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	198,455	198,455	71.00
72.00	07200	0	0	0	456,414	456,414	72.00
73.00	07300	0	0	0	1,139,660	1,139,660	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	79,447	12,537	91,984	-374	91,610	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	28,145	9,350	37,495	-37,495	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	-1,500	-1,500	79,481	77,981	90.00
91.00	09100	609,919	207,886	817,805	212,524	1,030,329	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	214,291	214,291	-214,291	0	95.00
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		13,750,363	27,500,517	41,250,880	-725,013	40,525,867	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	7,837	45,805	53,642	0	53,642	190.00
192.00	19200	0	3,503	3,503	19	3,522	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07955	0	0	0	415,867	415,867	194.01
194.02	07952	0	1,337	1,337	0	1,337	194.02
194.03	07953	0	0	0	309,127	309,127	194.03
194.04	07954	0	0	0	0	0	194.04
200.00		13,758,200	27,551,162	41,309,362	0	41,309,362	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A  
Date/Time Prepared:  
2/27/2013 3:50 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-34,662	1,948,376	1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT	156,777	156,777	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-370,663	1,934,829	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	-4,407	2,361,701	4.00
5.01	00510	NONPATIENT TELEPHONES	-106,607	404,728	5.01
5.02	00540	ADMINISTRATIVE	0	377,724	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	-4,826,384	750,502	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	-1,241,205	6,091,296	5.04
7.00	00700	OPERATION OF PLANT	0	2,004,776	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	16,325	195,661	8.00
9.00	00900	HOUSEKEEPING	0	569,616	9.00
10.00	01000	DIETARY	0	395,995	10.00
11.00	01100	CAFETERIA	-51,240	346,003	11.00
13.00	01300	NURSING ADMINISTRATION	-20,337	1,189,237	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	606,710	14.00
15.00	01500	PHARMACY	0	725,013	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,309	634,448	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-881,303	2,225,231	30.00
31.00	03100	INTENSIVE CARE UNIT	0	700,423	31.00
43.00	04300	NURSERY	0	219,841	43.00
44.00	04400	SKILLED NURSING FACILITY	0	594,350	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-63	1,298,039	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	145,721	52.00
53.00	05300	ANESTHESIOLOGY	-584,541	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,046,781	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	142,251	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	1,180,118	60.00
65.00	06500	RESPIRATORY THERAPY	0	446,846	65.00
66.00	06600	PHYSICAL THERAPY	0	752,829	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	135,977	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	198,455	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	456,414	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,139,660	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.01	03951	SLEEP LAB	0	91,610	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	77,981	90.00
91.00	09100	EMERGENCY	-181,291	849,038	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
99.10	09910	CORF	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-8,130,910	32,394,957	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	53,642	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,522	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	194.00
194.01	07955	MARKETING	-9,347	406,520	194.01
194.02	07952	SENIOR CIRCLE	0	1,337	194.02
194.03	07953	BUSINESS HEALTH	0	309,127	194.03
194.04	07954	VACANT SPACE	0	0	194.04
200.00		TOTAL (SUM OF LINES 118-199)	-8,140,257	33,169,105	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - EMPLOYEE BENEFITS</b>					
1.00	EMPLOYEE BENEFITS	4.00	0	2,115,602	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	19	2.00
	TOTALS		0	2,115,621	
<b>B - OXYGEN</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,683	1.00
	TOTALS		0	2,683	
<b>C - RENTAL AND LEASE EXPENSE</b>					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	331,789	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
	TOTALS		0	331,789	
<b>D - OTHER CAPITAL COSTS</b>					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	46,252	1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	399,628	2.00
3.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	13,562	3.00
	TOTALS		0	459,442	
<b>E - MARKETING</b>					
1.00	MARKETING	194.01	113,268	302,599	1.00
	TOTALS		113,268	302,599	
<b>F - CNO</b>					
1.00	NURSING ADMINISTRATION	13.00	215,337	0	1.00
	TOTALS		215,337	0	
<b>G - MEDICAL SUPPLIES AND IMPLANTS</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	195,772	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	456,414	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
	TOTALS		0	652,186	
<b>H - DRUGS AND IV</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,139,660	1.00
	TOTALS		0	1,139,660	
<b>I - LABOR AND DELIVERY</b>					
1.00	NURSERY	43.00	178,262	41,579	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	118,161	27,560	2.00
	TOTALS		296,423	69,139	
<b>J - MISC DEPARTMENT</b>					
1.00	OPERATING ROOM	50.00	323,985	110,799	1.00
2.00	PHYSICAL THERAPY	66.00	243,695	25,900	2.00
3.00	BUSINESS HEALTH	194.03	243,431	65,696	3.00
4.00	EMPLOYEE BENEFITS	4.00	70,613	14,563	4.00
5.00	CLINIC	90.00	60,418	19,063	5.00
6.00	EMERGENCY	91.00	0	214,291	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
	TOTALS		942,142	450,312	
<b>K - RADIOLOGY</b>					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	296,756	74,683	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00

RECLASSIFICATIONS

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-6

Date/Time Prepared:  
2/27/2013 3:50 pm

		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
	TOTALS			296,756	74,683	
	L - DIETARY					
1.00	CAFETERIA		11.00	230,378	166,865	1.00
	TOTALS			230,378	166,865	
	M - ADMINISTRATIVE AND GENERAL					
1.00	NONPATIENT TELEPHONES		5.01	79,791	431,544	1.00
2.00	ADMINISTRATIVE		5.02	334,667	43,057	2.00
3.00	CASHIERING/ACCOUNTS RECEIVABLE		5.03	325,233	5,251,653	3.00
	TOTALS			739,691	5,726,254	
500.00	Grand Total: Increases			2,833,995	11,491,233	500.00

RECLASSIFICATIONS

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-6  
Date/Time Prepared:  
2/27/2013 3:50 pm

		Decreases				Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
<b>A - EMPLOYEE BENEFITS</b>							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	2,115,621	0		1.00
2.00		0.00	0	0	0		2.00
	<b>TOTALS</b>		0	2,115,621			
<b>B - OXYGEN</b>							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,683	0		1.00
	<b>TOTALS</b>		0	2,683			
<b>C - RENTAL AND LEASE EXPENSE</b>							
1.00	EMPLOYEE BENEFITS	4.00	0	5,210	10		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	37,324	0		2.00
3.00	OPERATION OF PLANT	7.00	0	1,105	0		3.00
4.00	DIETARY	10.00	0	1,627	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	125	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	476	0		6.00
7.00	PHARMACY	15.00	0	83,268	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	7,170	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	27,597	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	1,411	0		10.00
11.00	SKILLED NURSING FACILITY	44.00	0	907	0		11.00
12.00	OPERATING ROOM	50.00	0	1,955	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	73,134	0		13.00
14.00	LABORATORY	60.00	0	83,563	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	2,001	0		15.00
16.00	PHYSICAL THERAPY	66.00	0	2,775	0		16.00
17.00	SLEEP LAB	76.01	0	374	0		17.00
18.00	EMERGENCY	91.00	0	1,767	0		18.00
	<b>TOTALS</b>		0	331,789			
<b>D - OTHER CAPITAL COSTS</b>							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	459,442	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	<b>TOTALS</b>		0	459,442			
<b>E - MARKETING</b>							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	113,268	302,599	0		1.00
	<b>TOTALS</b>		113,268	302,599			
<b>F - CNO</b>							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	215,337	0	0		1.00
	<b>TOTALS</b>		215,337	0			
<b>G - MEDICAL SUPPLIES AND IMPLANTS</b>							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	633,825	0		1.00
2.00	OPERATING ROOM	50.00	0	18,264	0		2.00
3.00	RECOVERY ROOM	51.00	0	50	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	34	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	13	0		5.00
	<b>TOTALS</b>		0	652,186			
<b>H - DRUGS AND IV</b>							
1.00	PHARMACY	15.00	0	1,139,660	0		1.00
	<b>TOTALS</b>		0	1,139,660			
<b>I - LABOR AND DELIVERY</b>							
1.00	ADULTS & PEDIATRICS	30.00	296,423	69,139	0		1.00
2.00		0.00	0	0	0		2.00
	<b>TOTALS</b>		296,423	69,139			
<b>J - MISC DEPARTMENT</b>							
1.00	RECOVERY ROOM	51.00	323,985	69,069	0		1.00
2.00	LABORATORY	60.00	215,286	57,846	0		2.00
3.00	OCCUPATIONAL THERAPY	67.00	174,107	17,331	0		3.00
4.00	NURSING ADMINISTRATION	13.00	70,613	14,563	0		4.00
5.00	SPEECH PATHOLOGY	68.00	69,588	8,570	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	60,418	17,563	0		6.00
7.00	RURAL HEALTH CLINIC	88.00	28,145	9,350	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	41,729	0		8.00
9.00	AMBULANCE SERVICES	95.00	0	214,291	0		9.00
	<b>TOTALS</b>		942,142	450,312			
<b>K - RADIOLOGY</b>							
1.00	ULTRA SOUND	54.01	105,780	13,094	0		1.00
2.00	CT SCAN	57.00	85,746	49,167	0		2.00
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	105,230	12,422	0		3.00
	<b>TOTALS</b>		296,756	74,683			

RECLASSIFICATIONS

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-6  
Date/Time Prepared:  
2/27/2013 3:50 pm

Decreases						Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
L - DIETARY							
1.00	DIETARY	10.00	230,378	166,865	0		1.00
	TOTALS		230,378	166,865			
M - ADMINISTRATIVE AND GENERAL							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	739,691	5,726,254	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		739,691	5,726,254			
500.00	Grand Total: Decreases		2,833,995	11,491,233			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
2/27/2013 3:50 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	1,742,966	36,506	0	36,506	0	2.00
3.00	Buildings and Fixtures	61,408,497	415,352	0	415,352	1,079,775	3.00
4.00	Building Improvements	10,901,466	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	2,756,284	0	2,756,284	0	7.00
8.00	Subtotal (sum of lines 1-7)	74,052,929	3,208,142	0	3,208,142	1,079,775	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	74,052,929	3,208,142	0	3,208,142	1,079,775	10.00
<b>SUMMARY OF CAPITAL</b>							
Cost Center Description		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,537,158	0	0	0	0	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,960,141	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,497,299	0	0	0	0	3.00
<b>COMPUTATION OF RATIOS</b>							
Cost Center Description		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,537,158	0	1,537,158	0.439527	0	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,960,141	0	1,960,141	0.560473	0	2.00
3.00	Total (sum of lines 1-2)	3,497,299	0	3,497,299	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
2/27/2013 3:50 pm

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	0	0			1.00	
2.00	Land Improvements	1,779,472	0			2.00	
3.00	Buildings and Fixtures	60,744,074	0			3.00	
4.00	Building Improvements	10,901,466	0			4.00	
5.00	Fixed Equipment	0	0			5.00	
6.00	Movable Equipment	0	0			6.00	
7.00	HIT designated Assets	2,756,284	0			7.00	
8.00	Subtotal (sum of lines 1-7)	76,181,296	0			8.00	
9.00	Reconciling Items	0	0			9.00	
10.00	Total (line 8 minus line 9)	76,181,296	0			10.00	
<b>SUMMARY OF CAPITAL</b>							
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,537,158			1.00	
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0			1.01	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,960,141			2.00	
3.00	Total (sum of lines 1-2)	0	3,497,299			3.00	
<b>ALLOCATION OF OTHER CAPITAL</b>							
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,241,662	-107,698	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	0	156,777	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,494,211	331,789	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,892,650	224,091	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
2/27/2013 3:50 pm

Cost Center Description		SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
		11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS								
1.00	NEW CAP REL COSTS-BLDG & FIXT	368,532	46,252	399,628	0	1,948,376	1.00	
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	0	0	156,777	1.01	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	95,267	13,562	0	0	1,934,829	2.00	
3.00	Total (sum of lines 1-2)	463,799	59,814	399,628	0	4,039,982	3.00	

ADJUSTMENTS TO EXPENSES

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-8

Date/Time Prepared:  
2/27/2013 3:50 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted	
			Cost Center	Line #
			1.00	2.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			NEW CAP REL COSTS-BLDG & FIXT	1.00 1.00
1.01 Investment income - WELLS CRC COSTS-BLDG & FIXT (chapter 2)			WELLS CRC COSTS-BLDG & FIXT	1.01 1.01
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			NEW CAP REL COSTS-MVBLE EQUIP	2.00 2.00
3.00 Investment income - other (chapter 2)		0		0.00 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00 7.00
8.00 Television and radio service (chapter 21)		0		0.00 8.00
9.00 Parking lot (chapter 21)		0		0.00 9.00
10.00 Provider-based physician adjustment	A-8-2	-1,100,312		10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-424,964		12.00
13.00 Laundry and linen service		0		0.00 13.00
14.00 Cafeteria-employees and guests	B	-51,240	CAFETERIA	11.00 14.00
15.00 Rental of quarters to employee and others		0		0.00 15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00 16.00
17.00 Sale of drugs to other than patients		0		0.00 17.00
18.00 Sale of medical records and abstracts	B	-1,309	MEDICAL RECORDS & LIBRARY	16.00 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00 19.00
20.00 Vending machines	B	-1,163	OTHER ADMINISTRATIVE AND GENERAL	5.04 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		RESPIRATORY THERAPY	65.00 23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00 24.00
25.00 Utilization review - physicians' compensation (chapter 21)			*** Cost Center Deleted ***	114.00 25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT	A	-295,496	NEW CAP REL COSTS-BLDG & FIXT	1.00 26.00
26.01 Depreciation - WELLS CRC COSTS-BLDG & FIXT	A	156,777	WELLS CRC COSTS-BLDG & FIXT	1.01 26.01
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	A	-465,930	NEW CAP REL COSTS-MVBLE EQUIP	2.00 27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00 28.00
29.00 Physicians' assistant		0		0.00 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00 30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		SPEECH PATHOLOGY	68.00 31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00 32.00
33.00 FITNESS REVENUE	B	-248,579	OTHER ADMINISTRATIVE AND GENERAL	5.04 33.00
34.00 MISC REVENUE	B	-108,827	OTHER ADMINISTRATIVE AND GENERAL	5.04 34.00
35.00 BAD DEBT	A	-4,730,745	CASHIERING/ACCOUNTS RECEIVABLE	5.03 35.00
36.00 LOST CHARGES	A	-63	OPERATING ROOM	50.00 36.00
37.00 PHYSICIAN RECRUITING	A	9,686	OTHER ADMINISTRATIVE AND GENERAL	5.04 37.00
38.00 LOBBYING IN ASSOCIATION DUES	A	-2,136	OTHER ADMINISTRATIVE AND GENERAL	5.04 38.00
40.00 CHARITABLE CONTRIBUTIONS	A	-7,631	OTHER ADMINISTRATIVE AND GENERAL	5.04 40.00
41.00 LOBBYING EXPENSE	A	-505	OTHER ADMINISTRATIVE AND GENERAL	5.04 41.00

Provider CCN: 150075  
 Period: From 10/01/2011 To 09/30/2012  
 Worksheet A-8  
 Date/Time Prepared: 2/27/2013 3:50 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center			Line #
			1.00	2.00		3.00
42.00 PENALTIES	A	-186	OTHER ADMINIS	TRATIVE AND GENERAL	5.04	42.00
43.00 CRNA	A	-584,541	ANESTHESIOLOGY		53.00	43.00
44.00 PATIENT PHONE WAGES	A	-19,512	NONPATIENT TELEPHONES		5.01	44.00
45.00 PATIENT PHONE BENEFITS	A	-4,407	EMPLOYEE BENEFITS		4.00	45.00
45.01 PATIENT PHONE SERVICE EXPENSE	A	-87,095	NONPATIENT TELEPHONES		5.01	45.01
45.02 RENTAL INCOME	B	-107,698	NEW CAP REL COSTS-BLDG & FI XT		1.00	45.02
45.03 PATIENT TV EXPENSE	A	-16,129	OTHER ADMINIS	TRATIVE AND GENERAL	5.04	45.03
45.04 MARKETING	A	-6,604	OTHER ADMINIS	TRATIVE AND GENERAL	5.04	45.04
45.06 SPECIAL EVENTS	A	-1,125	OTHER ADMINIS	TRATIVE AND GENERAL	5.04	45.06
45.07 MEDICAL STAFF AND BOARD RELATIONS	A	-21,819	OTHER ADMINIS	TRATIVE AND GENERAL	5.04	45.07
45.08 LEGAL FEES	A	-18,704	OTHER ADMINIS	TRATIVE AND GENERAL	5.04	45.08
45.09		0			0.00	45.09
45.10		0			0.00	45.10
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,140,257				50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-8

Date/Time Prepared:  
2/27/2013 3:50 pm

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
1.01	Investment income - WELLS CRC COSTS-BLDG & FIXT (chapter 2)	0	1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	9	26.00
26.01	Depreciation - WELLS CRC COSTS-BLDG & FIXT	9	26.01
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	9	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	FITNESS REVENUE	0	33.00
34.00	MISC REVENUE	0	34.00
35.00	BAD DEBT	0	35.00
36.00	LOST CHARGES	0	36.00
37.00	PHYSICIAN RECRUITING	0	37.00
38.00	LOBBYING IN ASSOCIATION DUES	0	38.00
40.00	CHARITABLE CONTRIBUTIONS	0	40.00
41.00	LOBBYING EXPENSE	0	41.00
42.00	PENALTIES	0	42.00
43.00	CRNA	0	43.00
44.00	PATIENT PHONE WAGES	0	44.00
45.00	PATIENT PHONE BENEFITS	0	45.00
45.01	PATIENT PHONE SERVICE EXPENSE	0	45.01
45.02	RENTAL INCOME	10	45.02
45.03	PATIENT TV EXPENSE	0	45.03
45.04	MARKETING	0	45.04
45.06	SPECIAL EVENTS	0	45.06
45.07	MEDICAL STAFF AND BOARD RELATIONS	0	45.07
45.08	LEGAL FEES	0	45.08
45.09		0	45.09
45.10		0	45.10
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

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

Provider CCN: 150075

Period: From 10/01/2011 To 09/30/2012

Worksheet A-8-1

Date/Time Prepared: 2/27/2013 3:50 pm

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	5.04	OTHER ADMINISTRATIVE AND GENERAL	MANAGEMENT FEES	1.00
2.00	5.04	OTHER ADMINISTRATIVE AND GENERAL	401K FEES	2.00
3.00	5.04	OTHER ADMINISTRATIVE AND GENERAL	AUDIT FEES	3.00
4.00	5.04	OTHER ADMINISTRATIVE AND GENERAL	MIS FEES	4.00
4.01	5.04	OTHER ADMINISTRATIVE AND GENERAL	MANAGED CARE FEES	4.01
4.02	5.04	OTHER ADMINISTRATIVE AND GENERAL	CASE MANAGEMENT FEES	4.02
4.03	5.04	OTHER ADMINISTRATIVE AND GENERAL	PURCHASE & ANCI LLARY FEES	4.03
4.04	5.04	OTHER ADMINISTRATIVE AND GENERAL	ER	4.04
4.05	5.04	OTHER ADMINISTRATIVE AND GENERAL	PPSI FEES	4.05
4.06	5.04	OTHER ADMINISTRATIVE AND GENERAL	COMPLIANCE/HIM/CCA FEES	4.06
4.07	194.01	MARKETING	SENI OR CI RCLE	4.07
4.08	5.03	CASHI ERING/ACCOUNTS RECEI VABLE	PASI OPERATING	4.08
4.09	1.00	NEW CAP REL COSTS-BLDG & FI XT	PASI CAPITAL	4.09
4.10	2.00	NEW CAP REL COSTS-MVBLE EQUI P	PASI CAPITAL	4.10
4.11	5.03	CASHI ERING/ACCOUNTS RECEI VABLE	PASI CALL CENTER	4.11
4.12	5.03	CASHI ERING/ACCOUNTS RECEI VABLE	PASI LI EN UNIT	4.12
4.13	1.00	NEW CAP REL COSTS-BLDG & FI XT	DI RECT INTEREST	4.13
4.14	1.00	NEW CAP REL COSTS-BLDG & FI XT	POOLED CAPITAL - BLDG	4.14
4.15	2.00	NEW CAP REL COSTS-MVBLE EQUI P	POOLED CAPITAL - FF&E	4.15
4.16	5.04	OTHER ADMINISTRATIVE AND GENERAL	POOLED HOME OFFICE COSTS	4.16
4.17	8.00	LAUNDRY & LI NEN SERVICE	LAUNDRY SERVI CE	4.17
4.18	5.04	OTHER ADMINISTRATIVE AND GENERAL	MALPRACTICE	4.18
4.19	5.04	OTHER ADMINISTRATIVE AND GENERAL	CONVERSI ON COSTS	4.19
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5.00

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

	Symbol (1)	Name	Percentage of Ownership	
	1.00	2.00	3.00	

**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	6.00
7.00			0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (fi nanci al or non-fi nanci al) speci fy:			100.00

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

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-8-1

Date/Time Prepared:  
2/27/2013 3:50 pm

	Symbol (1)	Name	Percentage of Ownership		
	1.00	2.00	3.00		

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

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

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

Provider CCN: 150075

Period: From 10/01/2011 To 09/30/2012

Worksheet A-8-1

Date/Time Prepared: 2/27/2013 3:50 pm

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	4.00	5.00	6.00	7.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00		862,409	-862,409	0	1.00
2.00		1,199	-1,199	0	2.00
3.00		24,157	-24,157	0	3.00
4.00		160,482	-160,482	0	4.00
4.01		14,520	-14,520	0	4.01
4.02		42,898	-42,898	0	4.02
4.03		4,023	-4,023	0	4.03
4.04		22,492	-22,492	0	4.04
4.05		14,325	-14,325	0	4.05
4.06		12,298	-12,298	0	4.06
4.07		9,347	-9,347	0	4.07
4.08	97,913	183,880	-85,967	0	4.08
4.09	6,915	0	6,915	11	4.09
4.10	4,228	0	4,228	11	4.10
4.11	0	5,399	-5,399	0	4.11
4.12	0	4,273	-4,273	0	4.12
4.13	347,028	0	347,028	11	4.13
4.14	14,589	0	14,589	11	4.14
4.15	91,039	0	91,039	11	4.15
4.16	705,743	0	705,743	0	4.16
4.17	195,661	179,336	16,325	0	4.17
4.18	3,686	369,059	-365,373	0	4.18
4.19	18,331	0	18,331	0	4.19
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	1,485,133	1,910,097	-424,964	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			
Name	Percentage of Ownership	Type of Business	
4.00	5.00	6.00	
<b>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>			

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

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

6.00		CHS, INC.	100.00	HEALTHCARE	6.00
7.00			0.00		7.00
8.00			0.00		8.00
9.00			0.00		9.00
10.00			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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-8-2

Date/Time Prepared:  
2/27/2013 3:50 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	5.04	OTHER ADMINISTRATIVE AND GENERAL	17,381	17,381	1.00
2.00	13.00	NURSING ADMINISTRATION	45,000	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	881,303	881,303	3.00
4.00	91.00	EMERGENCY	181,291	181,291	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
200.00			1,124,975	1,079,975	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-8-2

Date/Time Prepared:  
2/27/2013 3:50 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	0	142,500	0	0	0	1.00
2.00	45,000	142,500	360	24,663	1,233	2.00
3.00	0	142,500	0	0	0	3.00
4.00	0	142,500	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	45,000		360	24,663	1,233	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-8-2

Date/Time Prepared:  
2/27/2013 3:50 pm

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 16.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	24,663	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	0	0	0	0	24,663	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-8-2

Date/Time Prepared:  
2/27/2013 3:50 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	17,381	1.00
2.00	20,337	20,337	2.00
3.00	0	881,303	3.00
4.00	0	181,291	4.00
5.00	0	0	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	20,337	1,100,312	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B  
Part I  
Date/Time Prepared:  
2/27/2013 3:50 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS		
		NEW BLDG & FIXT	WELLS CRC COSTS-BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	1.01	2.00	4.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	1,948,376	1,948,376			1.00	
1.01 00101	WELLS CRC COSTS-BLDG & FIXT	156,777	0	156,777		1.01	
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	1,934,829			1,934,829	2.00	
4.00 00400	EMPLOYEE BENEFITS	2,361,701	0	2,007	14,116	2,377,824	4.00
5.01 00510	NONPATIENT TELEPHONES	404,728	9,762	0	9,062	13,997	5.01
5.02 00540	ADMITTING	377,724	12,940	0	0	58,710	5.02
5.03 00550	CASHIERING/ACCOUNTS RECEIVABLE	750,502	19,059	0	0	57,055	5.03
5.04 00560	OTHER ADMINISTRATIVE AND GENERAL	6,091,296	160,668	1,003	19,070	245,282	5.04
7.00 00700	OPERATION OF PLANT	2,004,776	112,709	0	104,622	91,077	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	195,661	1,901	3,580	26,946	0	8.00
9.00 00900	HOUSEKEEPING	569,616	8,029	0	7,453	61,373	9.00
10.00 01000	DIETARY	395,995	78,879	0	73,219	40,288	10.00
11.00 01100	CAFETERIA	346,003	0	4,609	32,423	40,415	11.00
13.00 01300	NURSING ADMINISTRATION	1,189,237	3,960	0	3,676	180,408	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	606,710	97,799	0	90,782	25,703	14.00
15.00 01500	PHARMACY	725,013	0	0	0	96,124	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	634,448	23,247	0	21,579	79,902	16.00
17.00 01700	SOCIAL SERVICE	0	3,792	0	3,520	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	2,225,231	165,153	0	153,303	314,667	30.00
31.00 03100	INTENSIVE CARE UNIT	700,423	29,098	0	27,010	108,291	31.00
43.00 04300	NURSERY	219,841	4,841	0	4,494	31,272	43.00
44.00 04400	SKILLED NURSING FACILITY	594,350	59,077	0	54,838	88,992	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	1,298,039	155,431	0	144,278	167,038	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	145,721	5,703	0	5,294	20,729	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,046,781	108,205	0	100,441	150,001	54.00
54.01 03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00 05600	RADIOISOTOPE	142,251	7,049	0	6,543	10,559	56.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00 06000	LABORATORY	1,180,118	44,811	0	41,595	109,200	60.00
65.00 06500	RESPIRATORY THERAPY	446,846	52,563	0	48,791	66,708	65.00
66.00 06600	PHYSICAL THERAPY	752,829	48,781	0	45,280	116,888	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	135,977	0	1,693	11,911	7,664	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	198,455	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	456,414	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,139,660	14,505	1,914	26,928	0	73.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01 03951	SLEEP LAB	91,610	3,436	0	3,189	13,937	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
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
90.00 09000	CLINIC	77,981	10,633	0	9,870	10,599	90.00
91.00 09100	EMERGENCY	849,038	47,107	0	43,727	106,996	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10 09910	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	32,394,957	1,289,138	14,806	1,133,960	2,313,875	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	53,642	9,138	0	8,483	1,375	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	3,522	593,389	21,333	700,869	0	192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTER	0	35,058	0	32,543	0	194.00
194.01 07955	MARKETING	406,520	21,653	0	20,099	19,870	194.01
194.02 07952	SENIOR CIRCLE	1,337	0	0	1,337	0	194.02
194.03 07953	BUSINESS HEALTH	309,127	0	5,527	38,875	42,704	194.03
194.04 07954	VACANT SPACE	0	0	115,111	0	0	194.04
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	33,169,105	1,948,376	156,777	1,934,829	2,377,824	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B  
Part I  
Date/Time Prepared:  
2/27/2013 3:50 pm

Cost Center Description		NONPATIENT TELEPHONES	Subtotal	ADMINISTRATIVE	Subtotal	CASHIERING/ACCOUNTS RECEIVABLE	
		5.01	5A.01	5.02	5A.02	5.03	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00510	NONPATIENT TELEPHONES	437,549				5.01
5.02	00540	ADMINISTRATIVE	7,099	456,473	456,473		5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	5,163	831,779	11,607	843,386	843,386
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	33,558	6,550,877	91,412	6,642,289	173,308
7.00	00700	OPERATION OF PLANT	7,744	2,320,928	32,386	2,353,314	61,398
8.00	00800	LAUNDRY & LINEN SERVICE	645	228,733	3,192	231,925	6,051
9.00	00900	HOUSEKEEPING	1,291	647,762	9,039	656,801	17,136
10.00	01000	DIETARY	5,808	594,189	8,291	602,480	15,719
11.00	01100	CAFETERIA	0	423,450	5,909	429,359	11,202
13.00	01300	NURSING ADMINISTRATION	1,936	1,379,217	19,246	1,398,463	36,486
14.00	01400	CENTRAL SERVICES & SUPPLY	3,227	824,221	11,501	835,722	21,804
15.00	01500	PHARMACY	7,099	828,236	11,557	839,793	21,910
16.00	01600	MEDICAL RECORDS & LIBRARY	16,134	775,310	10,819	786,129	20,510
17.00	01700	SOCIAL SERVICE	1,291	8,603	120	8,723	228
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	12,907	2,871,261	40,066	2,911,327	75,957
31.00	03100	INTENSIVE CARE UNIT	3,227	868,049	12,113	880,162	22,963
43.00	04300	NURSERY	645	261,093	3,643	264,736	6,907
44.00	04400	SKILLED NURSING FACILITY	6,454	803,711	11,215	814,926	21,261
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	21,942	1,786,728	24,932	1,811,660	47,266
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,291	178,738	2,494	181,232	4,728
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,552	1,418,980	19,800	1,438,780	37,538
54.01	03630	ULTRA SOUND	0	0	0	0	0
56.00	05600	RADIOISOTOPE	1,291	167,693	2,340	170,033	4,436
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
60.00	06000	LABORATORY	12,262	1,387,986	19,368	1,407,354	36,718
65.00	06500	RESPIRATORY THERAPY	1,936	616,844	8,607	625,451	16,318
66.00	06600	PHYSICAL THERAPY	3,227	967,005	13,494	980,499	25,581
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	3,872	161,117	2,248	163,365	4,262
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	198,455	2,769	201,224	5,250
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	456,414	6,369	462,783	12,074
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,183,007	16,508	1,199,515	31,295
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.01	03951	SLEEP LAB	0	112,172	1,565	113,737	2,967
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	3,227	112,310	1,567	113,877	2,971
91.00	09100	EMERGENCY	10,971	1,057,839	14,761	1,072,600	27,984
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	187,799	30,479,180	418,938	30,441,645	772,228
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,581	75,219	1,050	76,269	1,990
192.00	19200	PHYSICIANS' PRIVATE OFFICES	245,878	1,564,991	21,838	1,586,829	41,400
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	67,601	943	68,544	1,788
194.01	07955	MARKETING	1,291	469,433	6,550	475,983	12,418
194.02	07952	SENIOR CIRCLE	0	1,337	19	1,356	35
194.03	07953	BUSINESS HEALTH	0	396,233	5,529	401,762	10,482
194.04	07954	VACANT SPACE	0	115,111	1,606	116,717	3,045
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	437,549	33,169,105	456,473	33,169,105	843,386

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B  
Part I  
Date/Time Prepared:  
2/27/2013 3:50 pm

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL 5.04	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00510	NONPATIENT TELEPHONES					5.01
5.02	00540	ADMITTING					5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	6,815,597				5.04
7.00	00700	OPERATION OF PLANT	0	2,414,712			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	36,392	274,368		8.00
9.00	00900	HOUSEKEEPING	0	10,066	0	684,003	9.00
10.00	01000	DIETARY	0	98,885	0	28,560	10.00
11.00	01100	CAFETERIA	0	43,789	0	12,647	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,965	0	1,434	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	122,604	0	35,411	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	29,143	0	8,417	16.00
17.00	01700	SOCIAL SERVICE	0	4,754	0	1,373	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	525,815	207,042	141,441	59,798	595,977
31.00	03100	INTENSIVE CARE UNIT	105,601	36,478	14,272	10,536	26,537
43.00	04300	NURSERY	27,229	6,069	0	1,753	0
44.00	04400	SKILLED NURSING FACILITY	96,784	74,061	27,519	21,391	123,130
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	1,087,892	194,854	54,091	56,278	0
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,048	7,149	0	2,065	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,192,973	135,649	0	39,178	0
54.01	03630	ULTRA SOUND	0	0	0	0	0
56.00	05600	RADIOISOTOPE	37,666	8,837	0	2,552	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
60.00	06000	LABORATORY	1,499,162	56,176	0	16,225	0
65.00	06500	RESPIRATORY THERAPY	209,078	65,894	0	19,032	0
66.00	06600	PHYSICAL THERAPY	185,697	61,153	34	17,662	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	128,332	16,086	0	4,646	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	271,805	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	177,675	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	612,506	36,367	0	10,503	0
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.01	03951	SLEEP LAB	67,579	4,307	670	1,244	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	26,649	13,330	0	3,850	0
91.00	09100	EMERGENCY	545,106	59,056	36,341	17,057	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,815,597	1,333,106	274,368	371,612	745,644
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,456	0	3,309	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	946,553	0	273,384	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	43,950	0	12,694	0
194.01	07955	MARKETING	0	27,145	0	7,840	0
194.02	07952	SENIOR CIRCLE	0	0	0	0	0
194.03	07953	BUSINESS HEALTH	0	52,502	0	15,164	0
194.04	07954	VACANT SPACE	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	6,815,597	2,414,712	274,368	684,003	745,644

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B  
Part I  
Date/Time Prepared:  
2/27/2013 3:50 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00540						5.02
5.03	00550						5.03
5.04	00560						5.04
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	496,997					11.00
13.00	01300	34,790	1,476,138				13.00
14.00	01400	9,035	0	1,024,576			14.00
15.00	01500	20,466	0	36,129	918,298		15.00
16.00	01600	32,145	0	10,198	0	886,542	16.00
17.00	01700	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	105,583	729,317	109,077	0	68,397	30.00
31.00	03100	27,325	188,751	16,794	0	13,736	31.00
43.00	04300	8,098	55,940	0	0	3,542	43.00
44.00	04400	31,043	0	18,440	0	12,590	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	37,737	260,674	92,786	0	141,512	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	5,371	37,103	0	0	2,348	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	39,114	0	35,740	0	155,180	54.00
54.01	03630	0	0	0	0	0	54.01
56.00	05600	2,093	0	31,753	0	4,900	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	40,546	0	244,289	0	194,985	60.00
65.00	06500	17,271	0	7,591	0	27,197	65.00
66.00	06600	30,685	0	8,758	0	24,155	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	2,204	0	0	0	16,693	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	98,444	0	35,356	71.00
72.00	07200	0	0	226,200	0	23,112	72.00
73.00	07300	0	0	0	918,298	79,674	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	4,049	0	2,596	0	8,791	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	2,396	0	4,231	0	3,467	90.00
91.00	09100	29,583	204,353	49,402	0	70,907	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		479,534	1,476,138	992,428	918,298	886,542	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	606	0	22,299	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07955	0	0	1,641	0	0	194.01
194.02	07952	4,407	0	0	0	0	194.02
194.03	07953	12,450	0	8,208	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		496,997	1,476,138	1,024,576	918,298	886,542	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B  
Part I  
Date/Time Prepared:  
2/27/2013 3:50 pm

Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS				4.00
5.01	00510	NONPATIENT TELEPHONES				5.01
5.02	00540	ADMITTING				5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE				5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL				5.04
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	15,078			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	9,269	5,539,000	0	5,539,000
31.00	03100	INTENSIVE CARE UNIT	1,112	1,344,267	0	1,344,267
43.00	04300	NURSERY	759	375,033	0	375,033
44.00	04400	SKILLED NURSING FACILITY	3,938	1,245,083	0	1,245,083
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	0	3,784,750	0	3,784,750
51.00	05100	RECOVERY ROOM	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	258,044	0	258,044
53.00	05300	ANESTHESIOLOGY	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,074,152	0	3,074,152
54.01	03630	ULTRASOUND	0	0	0	0
56.00	05600	RADIOISOTOPE	0	262,270	0	262,270
57.00	05700	CT SCAN	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0
60.00	06000	LABORATORY	0	3,495,455	0	3,495,455
65.00	06500	RESPIRATORY THERAPY	0	987,832	0	987,832
66.00	06600	PHYSICAL THERAPY	0	1,334,224	0	1,334,224
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	335,588	0	335,588
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	612,079	0	612,079
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	901,844	0	901,844
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,888,158	0	2,888,158
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0
76.01	03951	SLEEP LAB	0	205,940	0	205,940
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0
90.00	09000	CLINIC	0	170,771	0	170,771
91.00	09100	EMERGENCY	0	2,112,389	0	2,112,389
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	AMBULANCE SERVICES	0	0	0	0
99.10	09910	CORF	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,078	28,926,879	0	28,926,879
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	115,929	0	115,929
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,848,166	0	2,848,166
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	126,976	0	126,976
194.01	07955	MARKETING	0	525,027	0	525,027
194.02	07952	SENIOR CIRCLE	0	5,798	0	5,798
194.03	07953	BUSINESS HEALTH	0	500,568	0	500,568
194.04	07954	VACANT SPACE	0	119,762	0	119,762
200.00		Cross Foot Adjustments	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	15,078	33,169,105	0	33,169,105

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2013 3:50 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
		NEW BLDG & FIXT	WELLS CRC COSTS-BLDG & FIXT	NEW MVBLE EQUIP		
		1.00	1.01	2.00		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	WELLS CRC COSTS-BLDG & FIXT					1.01
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS	0	2,007	14,116	16,123	4.00
5.01 00510	NONPATIENT TELEPHONES	0	9,762	9,062	18,824	5.01
5.02 00540	ADMITTING	0	12,940	0	12,940	5.02
5.03 00550	CASHIERING/ACCOUNTS RECEIVABLE	0	19,059	0	19,059	5.03
5.04 00560	OTHER ADMINISTRATIVE AND GENERAL	0	160,668	1,003	180,741	5.04
7.00 00700	OPERATION OF PLANT	0	112,709	0	217,331	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	1,901	3,580	32,427	8.00
9.00 00900	HOUSEKEEPING	0	8,029	0	15,482	9.00
10.00 01000	DIETARY	0	78,879	0	152,098	10.00
11.00 01100	CAFETERIA	0	0	4,609	37,032	11.00
13.00 01300	NURSING ADMINISTRATION	0	3,960	0	7,636	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	97,799	0	188,581	14.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	23,247	0	44,826	16.00
17.00 01700	SOCIAL SERVICE	0	3,792	0	7,312	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	165,153	0	318,456	30.00
31.00 03100	INTENSIVE CARE UNIT	0	29,098	0	56,108	31.00
43.00 04300	NURSERY	0	4,841	0	9,335	43.00
44.00 04400	SKILLED NURSING FACILITY	0	59,077	0	113,915	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	155,431	0	299,709	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	5,703	0	10,997	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	108,205	0	208,646	54.00
54.01 03630	ULTRA SOUND	0	0	0	0	54.01
56.00 05600	RADIOISOTOPE	0	7,049	0	13,592	56.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00 06000	LABORATORY	0	44,811	0	86,406	60.00
65.00 06500	RESPIRATORY THERAPY	0	52,563	0	101,354	65.00
66.00 06600	PHYSICAL THERAPY	0	48,781	0	94,061	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	1,693	13,604	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	14,505	1,914	43,347	73.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.00
76.01 03951	SLEEP LAB	0	3,436	0	6,625	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
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
90.00 09000	CLINIC	0	10,633	9,870	20,503	90.00
91.00 09100	EMERGENCY	0	47,107	0	90,834	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
99.10 09910	CORF	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,289,138	14,806	2,437,904	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,138	0	17,621	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	593,389	21,333	1,315,591	192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTER	0	35,058	0	67,601	194.00
194.01 07955	MARKETING	0	21,653	0	41,752	194.01
194.02 07952	SENIOR CIRCLE	0	0	0	0	194.02
194.03 07953	BUSINESS HEALTH	0	0	5,527	44,402	194.03
194.04 07954	VACANT SPACE	0	0	115,111	115,111	194.04
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,948,376	156,777	4,039,982	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2013 3:50 pm

Cost Center Description		EMPLOYEE BENEFITS	NONPATIENT TELEPHONES	ADMINISTRATIVE	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	
		4.00	5.01	5.02	5.03	5.04	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.01	00510	16,123					5.01
5.02	00540	95	18,919				5.02
5.03	00550	398	307	13,645			5.03
5.04	00560	387	223	347	20,016		5.04
5.04	00560	1,662	1,451	2,735	4,119	190,708	5.04
7.00	00700	617	335	968	1,457	0	7.00
8.00	00800	0	28	95	144	0	8.00
9.00	00900	416	56	270	407	0	9.00
10.00	01000	273	251	248	373	0	10.00
11.00	01100	274	0	177	266	0	11.00
13.00	01300	1,223	84	575	866	0	13.00
14.00	01400	174	140	344	517	0	14.00
15.00	01500	652	307	345	520	0	15.00
16.00	01600	542	698	323	487	0	16.00
17.00	01700	0	56	4	5	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	2,140	558	1,197	1,802	14,715	30.00
31.00	03100	734	140	362	545	2,955	31.00
43.00	04300	212	28	109	164	762	43.00
44.00	04400	603	279	335	504	2,708	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	1,132	949	745	1,121	30,445	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	140	56	75	112	505	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	1,017	586	592	891	33,385	54.00
54.01	03630	0	0	0	0	0	54.01
56.00	05600	72	56	70	105	1,054	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	740	530	579	871	41,929	60.00
65.00	06500	452	84	257	387	5,851	65.00
66.00	06600	792	140	403	607	5,197	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	52	167	67	101	3,591	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	83	125	7,606	71.00
72.00	07200	0	0	190	286	4,972	72.00
73.00	07300	0	0	493	742	17,141	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	94	0	47	70	1,891	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	72	140	47	70	746	90.00
91.00	09100	725	474	441	664	15,255	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		15,690	8,123	12,523	18,328	190,708	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	9	112	31	47	0	190.00
192.00	19200	0	10,628	653	982	0	192.00
194.00	07950	0	0	28	42	0	194.00
194.01	07955	135	56	196	295	0	194.01
194.02	07952	0	0	1	1	0	194.02
194.03	07953	289	0	165	249	0	194.03
194.04	07954	0	0	48	72	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		16,123	18,919	13,645	20,016	190,708	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150075	Period: From 10/01/2011 To 09/30/2012	Worksheet B Part II Date/Time Prepared: 2/27/2013 3:50 pm
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Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
		7.00	8.00	9.00	10.00	11.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	WELLS CRC COSTS-BLDG & FIXT					1.01	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS					4.00	
5.01	00510	NONPATIENT TELEPHONES					5.01	
5.02	00540	ADMITTING					5.02	
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE					5.03	
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL					5.04	
7.00	00700	OPERATION OF PLANT	220,708				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	3,326	36,020			8.00	
9.00	00900	HOUSEKEEPING	920	0	17,551		9.00	
10.00	01000	DIETARY	9,038	0	733	163,014	10.00	
11.00	01100	CAFETERIA	4,002	0	325	0	11.00	
13.00	01300	NURSING ADMINISTRATION	454	0	37	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	11,206	0	909	0	14.00	
15.00	01500	PHARMACY	0	0	0	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	2,664	0	216	0	16.00	
17.00	01700	SOCIAL SERVICE	434	0	35	0	17.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	18,924	18,569	1,534	130,293	8,938	30.00
31.00	03100	INTENSIVE CARE UNIT	3,334	1,874	270	5,802	2,313	31.00
43.00	04300	NURSERY	555	0	45	0	686	43.00
44.00	04400	SKILLED NURSING FACILITY	6,769	3,613	549	26,919	2,628	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	17,810	7,101	1,444	0	3,195	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	653	0	53	0	455	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,399	0	1,005	0	3,311	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	808	0	65	0	177	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	5,135	0	416	0	3,433	60.00
65.00	06500	RESPIRATORY THERAPY	6,023	0	488	0	1,462	65.00
66.00	06600	PHYSICAL THERAPY	5,589	4	453	0	2,598	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	1,470	0	119	0	187	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,324	0	270	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	394	88	32	0	343	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
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
90.00	09000	CLINIC	1,218	0	99	0	203	90.00
91.00	09100	EMERGENCY	5,398	4,771	438	0	2,505	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	121,847	36,020	9,535	163,014	40,598	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,047	0	85	0	51	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	86,517	0	7,015	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	4,017	0	326	0	0	194.00
194.01	07955	MARKETING	2,481	0	201	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	373	194.02
194.03	07953	BUSINESS HEALTH	4,799	0	389	0	1,054	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	220,708	36,020	17,551	163,014	42,076	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150075	Period: From 10/01/2011 To 09/30/2012	Worksheet B Part II Date/Time Prepared: 2/27/2013 3:50 pm		
Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE
		13.00	14.00	15.00	16.00	17.00
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS				4.00
5.01	00510	NONPATIENT TELEPHONES				5.01
5.02	00540	ADMITTING				5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE				5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL				5.04
7.00	00700	OPERATION OF PLANT				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	13,820			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	202,636		14.00
15.00	01500	PHARMACY	0	7,145	10,702	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,017	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	7,846
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	6,828	21,573	0	4,200
31.00	03100	INTENSIVE CARE UNIT	1,767	3,322	0	843
43.00	04300	NURSERY	524	0	0	217
44.00	04400	SKILLED NURSING FACILITY	0	3,647	0	773
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	2,441	18,351	0	8,689
51.00	05100	RECOVERY ROOM	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	347	0	0	144
53.00	05300	ANESTHESIOLOGY	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,069	0	9,528
54.01	03630	ULTRA SOUND	0	0	0	0
56.00	05600	RADIOISOTOPE	0	6,280	0	301
57.00	05700	CT SCAN	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0
60.00	06000	LABORATORY	0	48,314	0	12,032
65.00	06500	RESPIRATORY THERAPY	0	1,501	0	1,670
66.00	06600	PHYSICAL THERAPY	0	1,732	0	1,483
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,025
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	19,470	0	2,171
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	44,737	0	1,419
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	10,702	4,892
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0
76.01	03951	SLEEP LAB	0	513	0	540
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0
90.00	09000	CLINIC	0	837	0	213
91.00	09100	EMERGENCY	1,913	9,770	0	4,354
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	AMBULANCE SERVICES	0	0	0	0
99.10	09910	CORF	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,820	196,278	10,702	54,494
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,410	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0
194.01	07955	MARKETING	0	325	0	0
194.02	07952	SENIOR CIRCLE	0	0	0	0
194.03	07953	BUSINESS HEALTH	0	1,623	0	0
194.04	07954	VACANT SPACE	0	0	0	0
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	13,820	202,636	10,702	54,494

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2013 3:50 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
1.01	00101				1.01
2.00	00200				2.00
4.00	00400				4.00
5.01	00510				5.01
5.02	00540				5.02
5.03	00550				5.03
5.04	00560				5.04
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	554,550	0	554,550	30.00
31.00	03100	80,948	0	80,948	31.00
43.00	04300	13,032	0	13,032	43.00
44.00	04400	165,291	0	165,291	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	393,132	0	393,132	50.00
51.00	05100	0	0	0	51.00
52.00	05200	13,537	0	13,537	52.00
53.00	05300	0	0	0	53.00
54.00	05400	278,429	0	278,429	54.00
54.01	03630	0	0	0	54.01
56.00	05600	22,580	0	22,580	56.00
57.00	05700	0	0	0	57.00
58.00	05800	0	0	0	58.00
60.00	06000	200,385	0	200,385	60.00
65.00	06500	119,529	0	119,529	65.00
66.00	06600	113,059	0	113,059	66.00
67.00	06700	0	0	0	67.00
68.00	06800	0	0	0	68.00
69.00	06900	20,383	0	20,383	69.00
70.00	07000	0	0	0	70.00
71.00	07100	29,455	0	29,455	71.00
72.00	07200	51,604	0	51,604	72.00
73.00	07300	80,911	0	80,911	73.00
76.00	03950	0	0	0	76.00
76.01	03951	10,637	0	10,637	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	0	0	0	88.00
89.00	08900	0	0	0	89.00
90.00	09000	24,148	0	24,148	90.00
91.00	09100	137,542	0	137,542	91.00
92.00	09200	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	0	0	0	95.00
99.10	09910	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		2,309,152	0	2,309,152	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	23,413	0	23,413	190.00
192.00	19200	1,421,386	0	1,421,386	192.00
194.00	07950	72,014	0	72,014	194.00
194.01	07955	45,441	0	45,441	194.01
194.02	07952	375	0	375	194.02
194.03	07953	52,970	0	52,970	194.03
194.04	07954	115,231	0	115,231	194.04
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		4,039,982	0	4,039,982	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B-1

Date/Time Prepared:  
2/27/2013 3:50 pm

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF TELEPHONES)	
		NEW BLDG & FIXT (SQUARE FEET)	WELLS CRC COSTS-BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)			
		1.00	1.01	2.00	4.00	5.01	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	196,792				1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT	0	119,997			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			210,530		2.00
4.00	00400	EMPLOYEE BENEFITS	0	1,536	1,536	13,554,467	4.00
5.01	00510	NONPATIENT TELEPHONES	986	0	986	79,791	678 5.01
5.02	00540	ADMITTING	1,307	0	0	334,667	11 5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	1,925	0	0	325,233	8 5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	16,228	768	2,075	1,398,197	52 5.04
7.00	00700	OPERATION OF PLANT	11,384	0	11,384	519,175	12 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	192	2,740	2,932	0	1 8.00
9.00	00900	HOUSEKEEPING	811	0	811	349,849	2 9.00
10.00	01000	DIETARY	7,967	0	7,967	229,654	9 10.00
11.00	01100	CAFETERIA	0	3,528	3,528	230,378	0 11.00
13.00	01300	NURSING ADMINISTRATION	400	0	400	1,028,392	3 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,878	0	9,878	146,517	5 14.00
15.00	01500	PHARMACY	0	0	0	547,943	11 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,348	0	2,348	455,472	25 16.00
17.00	01700	SOCIAL SERVICE	383	0	383	0	2 17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	16,681	0	16,681	1,793,707	20 30.00
31.00	03100	INTENSIVE CARE UNIT	2,939	0	2,939	617,297	5 31.00
43.00	04300	NURSERY	489	0	489	178,262	1 43.00
44.00	04400	SKILLED NURSING FACILITY	5,967	0	5,967	507,288	10 44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	15,699	0	15,699	952,177	34 50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	576	0	576	118,161	2 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,929	0	10,929	855,060	21 54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0 54.01
56.00	05600	RADIOISOTOPE	712	0	712	60,190	2 56.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
60.00	06000	LABORATORY	4,526	0	4,526	622,481	19 60.00
65.00	06500	RESPIRATORY THERAPY	5,309	0	5,309	380,262	3 65.00
66.00	06600	PHYSICAL THERAPY	4,927	0	4,927	666,307	5 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,296	1,296	43,687	6 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,465	1,465	2,930	0	0 73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0 76.00
76.01	03951	SLEEP LAB	347	0	347	79,447	0 76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
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
90.00	09000	CLINIC	1,074	0	1,074	60,418	5 90.00
91.00	09100	EMERGENCY	4,758	0	4,758	609,919	17 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
99.10	09910	CORF	0	0	0	0	0 99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	130,207	11,333	123,387	13,189,931	291 118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	923	0	923	7,837	4 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	59,934	16,328	76,262	0	381 192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	3,541	0	3,541	0	0 194.00
194.01	07955	MARKETING	2,187	0	2,187	113,268	2 194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0 194.02
194.03	07953	BUSINESS HEALTH	0	4,230	4,230	243,431	0 194.03
194.04	07954	VACANT SPACE	0	88,106	0	0	0 194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,948,376	156,777	1,934,829	2,377,824	437,549 202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B-1

Date/Time Prepared:  
2/27/2013 3:50 pm

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF TELEPHONES)	
		NEW BLDG & FIXT (SQUARE FEET)	WELLS CRC COSTS-BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)			
		1.00	1.01	2.00			
203.00	Unit cost multiplier (Wkst. B, Part I)	9.900687	1.306508	9.190277	0.175427	645.352507	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)				16,123	18,919	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)				0.001189	27.904130	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B-1

Date/Time Prepared:  
2/27/2013 3:50 pm

Cost Center Description		Reconciliation	ADMITTING (ACCUM. COST)	Reconciliation	CASHIERING/ACC OUNTS RECEIVABLE (ACCUM. COST)	OTHER ADMINISTRATIVE AND GENERAL (GROSS CHARGES)	
		5A.02	5.02	5A.03	5.03	5.04	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00540	-456,473	32,712,632				5.02
5.03	00550	0	831,779	-843,386	32,325,719		5.03
5.04	00560	0	6,550,877	0	6,642,289	139,220,774	5.04
7.00	00700	0	2,320,928	0	2,353,314	0	7.00
8.00	00800	0	228,733	0	231,925	0	8.00
9.00	00900	0	647,762	0	656,801	0	9.00
10.00	01000	0	594,189	0	602,480	0	10.00
11.00	01100	0	423,450	0	429,359	0	11.00
13.00	01300	0	1,379,217	0	1,398,463	0	13.00
14.00	01400	0	824,221	0	835,722	0	14.00
15.00	01500	0	828,236	0	839,793	0	15.00
16.00	01600	0	775,310	0	786,129	0	16.00
17.00	01700	0	8,603	0	8,723	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	2,871,261	0	2,911,327	10,740,782	30.00
31.00	03100	0	868,049	0	880,162	2,157,098	31.00
43.00	04300	0	261,093	0	264,736	556,195	43.00
44.00	04400	0	803,711	0	814,926	1,976,995	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	1,786,728	0	1,811,660	22,222,290	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	178,738	0	181,232	368,673	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	1,418,980	0	1,438,780	24,368,776	54.00
54.01	03630	0	0	0	0	0	54.01
56.00	05600	0	167,693	0	170,033	769,403	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	0	1,387,986	0	1,407,354	30,622,340	60.00
65.00	06500	0	616,844	0	625,451	4,270,821	65.00
66.00	06600	0	967,005	0	980,499	3,793,215	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	161,117	0	163,365	2,621,430	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	198,455	0	201,224	5,552,144	71.00
72.00	07200	0	456,414	0	462,783	3,629,359	72.00
73.00	07300	0	1,183,007	0	1,199,515	12,511,620	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	0	112,172	0	113,737	1,380,431	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	112,310	0	113,877	544,363	90.00
91.00	09100	0	1,057,839	0	1,072,600	11,134,839	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		-456,473	30,022,707	-843,386	29,598,259	139,220,774	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	75,219	0	76,269	0	190.00
192.00	19200	0	1,564,991	0	1,586,829	0	192.00
194.00	07950	0	67,601	0	68,544	0	194.00
194.01	07955	0	469,433	0	475,983	0	194.01
194.02	07952	0	1,337	0	1,356	0	194.02
194.03	07953	0	396,233	0	401,762	0	194.03
194.04	07954	0	115,111	0	116,717	0	194.04
200.00							200.00
201.00							201.00
202.00			456,473		843,386	6,815,597	202.00
203.00			0.013954		0.026090	0.048955	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B-1

Date/Time Prepared:  
2/27/2013 3:50 pm

Cost Center Description		Reconciliation	ADMITTING (ACCUM. COST)	Reconciliation	CASHIERING/ACC OUNTS RECEIVABLE (ACCUM. COST)	OTHER ADMINISTRATIVE AND GENERAL (GROSS CHARGES)	
		5A.02	5.02	5A.03	5.03	5.04	
204.00	Cost to be allocated (per Wkst. B, Part II)		13,645		20,016	190,708	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0.000417		0.000619	0.001370	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B-1

Date/Time Prepared:  
2/27/2013 3:50 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTEs)	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00510	NONPATIENT TELEPHONES					5.01
5.02	00540	ADMITTING					5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL					5.04
7.00	00700	OPERATION OF PLANT	194,549				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,932	301,387			8.00
9.00	00900	HOUSEKEEPING	811	0	190,806		9.00
10.00	01000	DIETARY	7,967	0	7,967	72,972	10.00
11.00	01100	CAFETERIA	3,528	0	3,528	0	18,043
13.00	01300	NURSING ADMINISTRATION	400	0	400	0	1,263
14.00	01400	CENTRAL SERVICES & SUPPLY	9,878	0	9,878	0	328
15.00	01500	PHARMACY	0	0	0	0	743
16.00	01600	MEDICAL RECORDS & LIBRARY	2,348	0	2,348	0	1,167
17.00	01700	SOCIAL SERVICE	383	0	383	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	16,681	155,369	16,681	58,325	3,833
31.00	03100	INTENSIVE CARE UNIT	2,939	15,678	2,939	2,597	992
43.00	04300	NURSERY	489	0	489	0	294
44.00	04400	SKILLED NURSING FACILITY	5,967	30,229	5,967	12,050	1,127
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	15,699	59,418	15,699	0	1,370
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	576	0	576	0	195
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,929	0	10,929	0	1,420
54.01	03630	ULTRA SOUND	0	0	0	0	0
56.00	05600	RADIO SOTOPE	712	0	712	0	76
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
60.00	06000	LABORATORY	4,526	0	4,526	0	1,472
65.00	06500	RESPIRATORY THERAPY	5,309	0	5,309	0	627
66.00	06600	PHYSICAL THERAPY	4,927	37	4,927	0	1,114
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	1,296	0	1,296	0	80
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	2,930	0	2,930	0	0
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.01	03951	SLEEP LAB	347	736	347	0	147
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	1,074	0	1,074	0	87
91.00	09100	EMERGENCY	4,758	39,920	4,758	0	1,074
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	107,406	301,387	103,663	72,972	17,409
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	923	0	923	0	22
192.00	19200	PHYSICIANS' PRIVATE OFFICES	76,262	0	76,262	0	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	3,541	0	3,541	0	0
194.01	07955	MARKETING	2,187	0	2,187	0	0
194.02	07952	SENIOR CIRCLE	0	0	0	0	160
194.03	07953	BUSINESS HEALTH	4,230	0	4,230	0	452
194.04	07954	VACANT SPACE	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	2,414,712	274,368	684,003	745,644	496,997
203.00		Unit cost multiplier (Wkst. B, Part I)	12.411845	0.910351	3.584809	10.218221	27.545142
204.00		Cost to be allocated (per Wkst. B, Part II)	220,708	36,020	17,551	163,014	42,076

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B-1

Date/Time Prepared:  
2/27/2013 3:50 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTEs)	
		7.00	8.00	9.00	10.00	11.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	1.134460	0.119514	0.091983	2.233925	2.331985	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B-1

Date/Time Prepared:  
2/27/2013 3:50 pm

Cost Center Description		NURSING ADMINISTRATION  (FTEs IN NURSING AREAS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (% COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE  (PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00540						5.02
5.03	00550						5.03
5.04	00560						5.04
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	7,758					13.00
14.00	01400	0	2,067,335				14.00
15.00	01500	0	72,899	100			15.00
16.00	01600	0	20,578	0	139,220,774		16.00
17.00	01700	0	0	0	0	11,323	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	3,833	220,089	0	10,740,782	6,961	30.00
31.00	03100	992	33,887	0	2,157,098	835	31.00
43.00	04300	294	0	0	556,195	570	43.00
44.00	04400	0	37,208	0	1,976,995	2,957	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	1,370	187,218	0	22,222,290	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	195	0	0	368,673	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	72,115	0	24,368,776	0	54.00
54.01	03630	0	0	0	0	0	54.01
56.00	05600	0	64,069	0	769,403	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	0	492,912	0	30,622,340	0	60.00
65.00	06500	0	15,317	0	4,270,821	0	65.00
66.00	06600	0	17,671	0	3,793,215	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	2,621,430	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	198,635	0	5,552,144	0	71.00
72.00	07200	0	456,414	0	3,629,359	0	72.00
73.00	07300	0	0	100	12,511,620	0	73.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	0	5,238	0	1,380,431	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	8,538	0	544,363	0	90.00
91.00	09100	1,074	99,680	0	11,134,839	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0	95.00
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		7,758	2,002,468	100	139,220,774	11,323	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	44,993	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07955	0	3,312	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	16,562	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00							200.00
201.00							201.00
202.00		1,476,138	1,024,576	918,298	886,542	15,078	202.00
203.00		190.273009	0.495602	9,182.980000	0.006368	1.331626	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B-1

Date/Time Prepared:  
2/27/2013 3:50 pm

Cost Center Description		NURSING ADMINISTRATION  (FTEs IN NURSING AREAS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (% COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE  (PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	13,820	202,636	10,702	54,494	7,846	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.781387	0.098018	107.020000	0.000391	0.692926	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2013 3:50 pm

		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS		5,539,000	0	5,539,000	30.00	
31.00	03100 INTENSIVE CARE UNIT		1,344,267	0	1,344,267	31.00	
43.00	04300 NURSERY		375,033	0	375,033	43.00	
44.00	04400 SKILLED NURSING FACILITY		1,245,083	0	1,245,083	44.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM		3,784,750	0	3,784,750	50.00	
51.00	05100 RECOVERY ROOM		0	0	0	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM		258,044	0	258,044	52.00	
53.00	05300 ANESTHESIOLOGY		0	0	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		3,074,152	0	3,074,152	54.00	
54.01	03630 ULTRA SOUND		0	0	0	54.01	
56.00	05600 RADIOISOTOPE		262,270	0	262,270	56.00	
57.00	05700 CT SCAN		0	0	0	57.00	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00	
60.00	06000 LABORATORY		3,495,455	0	3,495,455	60.00	
65.00	06500 RESPIRATORY THERAPY	0	987,832	0	987,832	65.00	
66.00	06600 PHYSICAL THERAPY	0	1,334,224	0	1,334,224	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		335,588	0	335,588	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY		0	0	0	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		612,079	0	612,079	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		901,844	0	901,844	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		2,888,158	0	2,888,158	73.00	
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS		0	0	0	76.00	
76.01	03951 SLEEP LAB		205,940	0	205,940	76.01	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC		0	0	0	88.00	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00	
90.00	09000 CLINIC		170,771	0	170,771	90.00	
91.00	09100 EMERGENCY		2,112,389	0	2,112,389	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		692,719	0	692,719	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES		0	0	0	95.00	
99.10	09910 CORF		0	0	0	99.10	
200.00	Subtotal (see instructions)		29,619,598	0	29,619,598	200.00	
201.00	Less Observation Beds		692,719	0	692,719	201.00	
202.00	Total (see instructions)		28,926,879	0	28,926,879	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2013 3:50 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,307,212		9,307,212		30.00
31.00	03100	INTENSIVE CARE UNIT	2,157,098		2,157,098		31.00
43.00	04300	NURSERY	556,195		556,195		43.00
44.00	04400	SKILLED NURSING FACILITY	1,976,995		1,976,995		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,725,334	15,496,956	22,222,290	0.170313	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	300,499	68,174	368,673	0.699926	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,735,676	19,633,100	24,368,776	0.126151	54.00
54.01	03630	ULTRA SOUND	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	136,674	632,729	769,403	0.340875	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	8,344,271	22,278,069	30,622,340	0.114147	60.00
65.00	06500	RESPIRATORY THERAPY	3,923,472	347,349	4,270,821	0.231298	65.00
66.00	06600	PHYSICAL THERAPY	1,896,269	1,896,946	3,793,215	0.351740	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,251,670	1,369,760	2,621,430	0.128017	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,206,430	2,345,714	5,552,144	0.110242	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,402,903	1,226,456	3,629,359	0.248486	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,029,013	5,482,607	12,511,620	0.230838	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	76.00
76.01	03951	SLEEP LAB	698	1,379,733	1,380,431	0.149185	76.01
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
90.00	09000	CLINIC	109,070	435,293	544,363	0.313708	90.00
91.00	09100	EMERGENCY	2,310,977	8,823,862	11,134,839	0.189710	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	65,622	1,367,948	1,433,570	0.483213	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
99.10	09910	CORF	0	0	0		99.10
200.00		Subtotal (see instructions)	56,436,078	82,784,696	139,220,774		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	56,436,078	82,784,696	139,220,774		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150075	Period: From 10/01/2011 To 09/30/2012	Worksheet C Part I Date/Time Prepared: 2/27/2013 3:50 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.170313		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.699926		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.126151		54.00
54.01	03630 ULTRA SOUND	0.000000		54.01
56.00	05600 RADIOISOTOPE	0.340875		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000 LABORATORY	0.114147		60.00
65.00	06500 RESPIRATORY THERAPY	0.231298		65.00
66.00	06600 PHYSICAL THERAPY	0.351740		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.128017		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.110242		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.248486		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.230838		73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
76.01	03951 SLEEP LAB	0.149185		76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000 CLINIC	0.313708		90.00
91.00	09100 EMERGENCY	0.189710		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.483213		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
99.10	09910 CORF			99.10
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2013 3:50 pm

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS		5,539,000	0	0	30.00	
31.00	03100 INTENSIVE CARE UNIT		1,344,267	0	0	31.00	
43.00	04300 NURSERY		375,033	0	0	43.00	
44.00	04400 SKILLED NURSING FACILITY		1,245,083	0	0	44.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM		3,784,750	0	0	50.00	
51.00	05100 RECOVERY ROOM		0	0	0	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM		258,044	0	0	52.00	
53.00	05300 ANESTHESIOLOGY		0	0	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		3,074,152	0	0	54.00	
54.01	03630 ULTRA SOUND		0	0	0	54.01	
56.00	05600 RADIOISOTOPE		262,270	0	0	56.00	
57.00	05700 CT SCAN		0	0	0	57.00	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00	
60.00	06000 LABORATORY		3,495,455	0	0	60.00	
65.00	06500 RESPIRATORY THERAPY	0	987,832	0	0	65.00	
66.00	06600 PHYSICAL THERAPY	0	1,334,224	0	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00	
69.00	06900 ELECTROCARDIOLOGY		335,588	0	0	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY		0	0	0	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		612,079	0	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		901,844	0	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		2,888,158	0	0	73.00	
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS		0	0	0	76.00	
76.01	03951 SLEEP LAB		205,940	0	0	76.01	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC		0	0	0	88.00	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00	
90.00	09000 CLINIC		170,771	0	0	90.00	
91.00	09100 EMERGENCY		2,112,389	0	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		692,719	0	0	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES		0	0	0	95.00	
99.10	09910 CORF		0	0	0	99.10	
200.00	Subtotal (see instructions)		29,619,598	0	0	200.00	
201.00	Less Observation Beds		692,719	0	0	201.00	
202.00	Total (see instructions)		28,926,879	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2013 3:50 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	9,307,212		9,307,212		30.00
31.00	03100	INTENSIVE CARE UNIT	2,157,098		2,157,098		31.00
43.00	04300	NURSERY	556,195		556,195		43.00
44.00	04400	SKILLED NURSING FACILITY	1,976,995		1,976,995		44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	6,725,334	15,496,956	22,222,290	0.170313	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	300,499	68,174	368,673	0.699926	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,735,676	19,633,100	24,368,776	0.126151	54.00
54.01	03630	ULTRA SOUND	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	136,674	632,729	769,403	0.340875	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	8,344,271	22,278,069	30,622,340	0.114147	60.00
65.00	06500	RESPIRATORY THERAPY	3,923,472	347,349	4,270,821	0.231298	65.00
66.00	06600	PHYSICAL THERAPY	1,896,269	1,896,946	3,793,215	0.351740	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,251,670	1,369,760	2,621,430	0.128017	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,206,430	2,345,714	5,552,144	0.110242	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,402,903	1,226,456	3,629,359	0.248486	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,029,013	5,482,607	12,511,620	0.230838	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	76.00
76.01	03951	SLEEP LAB	698	1,379,733	1,380,431	0.149185	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
90.00	09000	CLINIC	109,070	435,293	544,363	0.313708	90.00
91.00	09100	EMERGENCY	2,310,977	8,823,862	11,134,839	0.189710	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	65,622	1,367,948	1,433,570	0.483213	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
99.10	09910	CORF	0	0	0		99.10
200.00		Subtotal (see instructions)	56,436,078	82,784,696	139,220,774		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	56,436,078	82,784,696	139,220,774		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150075	Period: From 10/01/2011 To 09/30/2012	Worksheet C Part I Date/Time Prepared: 2/27/2013 3:50 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03630 ULTRA SOUND	0.000000		54.01
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
76.01	03951 SLEEP LAB	0.000000		76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
99.10	09910 CORF			99.10
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Provider CCN: 150075		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part I Date/Time Prepared: 2/27/2013 3:50 pm	
Cost Center Description			Title XVIII		Hospital		PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	554,550	0	554,550	7,956	69.70	30.00
31.00	03100	INTENSIVE CARE UNIT	80,948		80,948	835	96.94	31.00
43.00	04300	NURSERY	13,032		13,032	570	22.86	43.00
44.00	04400	SKILLED NURSING FACILITY	165,291		165,291	2,957	55.90	44.00
200.00		Total (lines 30-199)	813,821		813,821	12,318		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150075	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part I Date/Time Prepared: 2/27/2013 3:50 pm
		Title XVIII	Hospital	PPS

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	03000 ADULTS & PEDIATRICS	3,331	232,171	30.00
31.00	03100 INTENSIVE CARE UNIT	416	40,327	31.00
43.00	04300 NURSERY	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	1,954	109,229	44.00
200.00	Total (lines 30-199)	5,701	381,727	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150075	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part II Date/Time Prepared: 2/27/2013 3:50 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	393,132	22,222,290	0.017691	2,030,096	35,914	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	13,537	368,673	0.036718	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	278,429	24,368,776	0.011426	2,439,494	27,874	54.00
54.01	03630 ULTRA SOUND	0	0	0.000000	0	0	54.01
56.00	05600 RADIOISOTOPE	22,580	769,403	0.029347	84,488	2,479	56.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
60.00	06000 LABORATORY	200,385	30,622,340	0.006544	4,203,182	27,506	60.00
65.00	06500 RESPIRATORY THERAPY	119,529	4,270,821	0.027987	1,910,463	53,468	65.00
66.00	06600 PHYSICAL THERAPY	113,059	3,793,215	0.029806	252,210	7,517	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	20,383	2,621,430	0.007776	731,027	5,684	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	29,455	5,552,144	0.005305	1,346,967	7,146	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	51,604	3,629,359	0.014218	1,281,013	18,213	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	80,911	12,511,620	0.006467	3,071,410	19,863	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.01	03951 SLEEP LAB	10,637	1,380,431	0.007706	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
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
90.00	09000 CLINIC	24,148	544,363	0.044360	24,976	1,108	90.00
91.00	09100 EMERGENCY	137,542	11,134,839	0.012352	1,299,221	16,048	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	69,353	1,433,570	0.048378	41,146	1,991	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	1,564,684	125,223,274		18,715,693	224,811	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150075		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part III Date/Time Prepared: 2/27/2013 3:50 pm	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital	Swing-Bed Adjustment Amount (see instructions)	PPS
			1.00	2.00	3.00	4.00	5.00	Total Costs (sum of cols. 1 through 5, minus col. 4)
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0 30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0 31.00
43.00	04300	NURSERY	0	0	0	0	0	0 43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0 44.00
200.00		Total (lines 30-199)	0	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150075		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part III Date/Time Prepared: 2/27/2013 3:50 pm	
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)	PPS	
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,956	0.00	3,331	0		30.00
31.00	03100	INTENSIVE CARE UNIT	835	0.00	416	0		31.00
43.00	04300	NURSERY	570	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	2,957	0.00	1,954	0		44.00
200.00		Total (lines 30-199)	12,318		5,701	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet D  
Part IV  
Date/Time Prepared:  
2/27/2013 3:50 pm

Cost Center Description		Title XVIII				Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)			
		1.00	2.00	3.00	4.00	5.00			
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND		0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS		0	0	0	0	0	76.00
76.01	03951	SLEEP LAB		0	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>									
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
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50-199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet D  
Part IV  
Date/Time Prepared:  
2/27/2013 3:50 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	22,222,290	0.000000	0.000000	2,030,096	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	368,673	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	24,368,776	0.000000	0.000000	2,439,494	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	769,403	0.000000	0.000000	84,488	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	30,622,340	0.000000	0.000000	4,203,182	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,270,821	0.000000	0.000000	1,910,463	65.00
66.00	06600	PHYSICAL THERAPY	0	3,793,215	0.000000	0.000000	252,210	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,621,430	0.000000	0.000000	731,027	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,552,144	0.000000	0.000000	1,346,967	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,629,359	0.000000	0.000000	1,281,013	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,511,620	0.000000	0.000000	3,071,410	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.01	03951	SLEEP LAB	0	1,380,431	0.000000	0.000000	0	76.01
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
90.00	09000	CLINIC	0	544,363	0.000000	0.000000	24,976	90.00
91.00	09100	EMERGENCY	0	11,134,839	0.000000	0.000000	1,299,221	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,433,570	0.000000	0.000000	41,146	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	125,223,274			18,715,693	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet D  
Part IV  
Date/Time Prepared:  
2/27/2013 3:50 pm

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)	Hospital	PPS
		11.00	12.00	13.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	3,842,778	0		50.00
51.00	05100 RECOVERY ROOM	0	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	4,722,093	0		54.00
54.01	03630 ULTRA SOUND	0	0	0		54.01
56.00	05600 RADIOISOTOPE	0	181,073	0		56.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000 LABORATORY	0	449,573	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	69,461	0		65.00
66.00	06600 PHYSICAL THERAPY	0	158	0		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	0	512,027	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	337,527	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	535,136	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,929,701	0		73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
76.01	03951 SLEEP LAB	0	421,201	0		76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000 CLINIC	0	171,262	0		90.00
91.00	09100 EMERGENCY	0	1,680,749	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	340,118	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES	0	0	0		95.00
200.00	Total (lines 50-199)	0	15,192,857	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150075	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/27/2013 3:50 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			50.00
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	1.00	2.00	3.00	4.00	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0.170313	3,842,778	0	0	50.00
51.00 05100 RECOVERY ROOM	0.000000	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.699926	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.126151	4,722,093	0	0	54.00
54.01 03630 ULTRA SOUND	0.000000	0	0	0	54.01
56.00 05600 RADIOISOTOPE	0.340875	181,073	0	0	56.00
57.00 05700 CT SCAN	0.000000	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
60.00 06000 LABORATORY	0.114147	449,573	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.231298	69,461	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.351740	158	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.128017	512,027	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.110242	337,527	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.248486	535,136	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.230838	1,929,701	0	0	73.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	76.00
76.01 03951 SLEEP LAB	0.149185	421,201	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 08800 RURAL HEALTH CLINIC	0.000000				88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00 09000 CLINIC	0.313708	171,262	0	0	90.00
91.00 09100 EMERGENCY	0.189710	1,680,749	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.483213	340,118	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00 09500 AMBULANCE SERVICES	0.000000		0		95.00
200.00	Subtotal (see instructions)		15,192,857	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	201.00
202.00	Net Charges (line 200 +/- line 201)		15,192,857	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150075	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/27/2013 3:50 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			Hospital	PPS	
	PPS Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		5.00	6.00			7.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	654,475	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	595,697	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	54.01
56.00	05600	RADIOISOTOPE	61,723	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
60.00	06000	LABORATORY	51,317	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	16,066	0	0	65.00
66.00	06600	PHYSICAL THERAPY	56	0	0	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	65,548	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	37,210	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	132,974	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	445,448	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.00
76.01	03951	SLEEP LAB	62,837	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	53,726	0	0	90.00
91.00	09100	EMERGENCY	318,855	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	164,349	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	AMBULANCE SERVICES		0		95.00
200.00		Subtotal (see instructions)	2,660,281	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00		Net Charges (line 200 +/- line 201)	2,660,281	0	0	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150075 Component CCN: 155373	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/27/2013 3:50 pm
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM		0	0	0	0	50.00
51.00	05100 RECOVERY ROOM		0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY		0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		0	0	0	0	54.00
54.01	03630 ULTRA SOUND		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 MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	58.00
60.00	06000 LABORATORY		0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY		0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY		0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY		0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY		0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY		0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		0	0	0	0	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS		0	0	0	0	76.00
76.01	03951 SLEEP LAB		0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
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
90.00	09000 CLINIC		0	0	0	0	90.00
91.00	09100 EMERGENCY		0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES		0	0	0	0	95.00
200.00	Total (lines 50-199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150075 Component CCN: 155373	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/27/2013 3:50 pm
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	22,222,290	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	368,673	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	24,368,776	0.000000	0.000000	35,757	54.00
54.01	03630 ULTRA SOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600 RADIOISOTOPE	0	769,403	0.000000	0.000000	0	56.00
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
60.00	06000 LABORATORY	0	30,622,340	0.000000	0.000000	309,626	60.00
65.00	06500 RESPIRATORY THERAPY	0	4,270,821	0.000000	0.000000	365,340	65.00
66.00	06600 PHYSICAL THERAPY	0	3,793,215	0.000000	0.000000	906,609	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	2,621,430	0.000000	0.000000	4,009	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,552,144	0.000000	0.000000	259,223	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	3,629,359	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	12,511,620	0.000000	0.000000	695,263	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.01	03951 SLEEP LAB	0	1,380,431	0.000000	0.000000	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
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
90.00	09000 CLINIC	0	544,363	0.000000	0.000000	1,030	90.00
91.00	09100 EMERGENCY	0	11,134,839	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,433,570	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	125,223,274			2,576,857	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150075  
Component CCN: 155373

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet D  
Part IV  
Date/Time Prepared:  
2/27/2013 3:50 pm  
PPS

Title XVIII

Skilled Nursing Facility

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	03630 ULTRA SOUND	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 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
60.00	06000 LABORATORY	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.00
76.01	03951 SLEEP LAB	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150075	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/27/2013 3:50 pm
		Title XIX	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
			1.00	2.00		3.00	4.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0.170313	0	314,216	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.699926	0	3,650	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126151	0	706,391	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.340875	0	15,454	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
60.00	06000	LABORATORY	0.114147	0	879,547	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.231298	0	24,804	0	65.00
66.00	06600	PHYSICAL THERAPY	0.351740	0	45,786	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.128017	0	41,869	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.110242	0	48,671	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.248486	0	29,901	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.230838	0	192,256	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	76.00
76.01	03951	SLEEP LAB	0.149185	0	50,185	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0.000000				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00	09000	CLINIC	0.313708	0	24,004	0	90.00
91.00	09100	EMERGENCY	0.189710	0	456,218	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.483213	0	85,078	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0.000000	0	0		95.00
200.00		Subtotal (see instructions)		0	2,918,030	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	2,918,030	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150075	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/27/2013 3:50 pm
		Title XIX	Hospital	Cost

Cost Center Description	Costs			Hospital	Cost	
	PPS Services (see inst.)	Cost	Cost			
		Reimbursed Services Subject To Ded. & Coins. (see inst.)	Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
5.00	6.00	7.00				
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	0	53,515	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,555	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	89,112	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	5,268	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
60.00	06000	LABORATORY	0	100,398	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,737	0	65.00
66.00	06600	PHYSICAL THERAPY	0	16,105	0	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	0	5,360	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,366	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,430	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	44,380	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.00
76.01	03951	SLEEP LAB	0	7,487	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	7,530	0	90.00
91.00	09100	EMERGENCY	0	86,549	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	41,111	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
200.00		Subtotal (see instructions)	0	477,903	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)	0	477,903	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150075	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1 Date/Time Prepared: 2/27/2013 3:50 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,956	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,956	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.		215	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		6,746	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		3,331	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,539,000	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)		5,539,000	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		9,863,407	28.00
29.00	Private room charges (excluding swing-bed charges)		325,652	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		9,537,755	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.561571	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		1,514.66	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,413.84	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		100.82	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		56.62	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		12,173	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		5,526,827	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		696.20	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,319,042	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,319,042	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150075	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1 Date/Time Prepared: 2/27/2013 3:50 pm		
Cost Center Description			Title XVIII		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	1,344,267	835	1,609.90	416	669,718	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,236,256	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,225,016	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)					272,498	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					224,811	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					497,309	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					5,727,707	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)					995	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					696.20	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					692,719	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150075		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1 Date/Time Prepared: 2/27/2013 3:50 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	554,550	5,539,000	0.100117	692,719	69,353	90.00
91.00	Nursing School cost	0	5,539,000	0.000000	692,719	0	91.00
92.00	Allied health cost	0	5,539,000	0.000000	692,719	0	92.00
93.00	All other Medical Education	0	5,539,000	0.000000	692,719	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150075 Component CCN: 155373	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1 Date/Time Prepared: 2/27/2013 3:50 pm
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,957	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,957	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)		2,957	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,954	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,245,083	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)		1,245,083	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		1,976,995	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		1,976,995	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.629786	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)		668.58	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)		1,245,083	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150075	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1		
		Component CCN: 155373		Date/Time Prepared: 2/27/2013 3:50 pm		
		Title XVIII	Skilled Nursing Facility	PPS		
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)					42.00
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
	Cost Center Description					
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					49.00
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					53.00
	TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges					54.00
55.00	Target amount per discharge					55.00
56.00	Target amount (line 54 x line 55)					56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					57.00
58.00	Bonus payment (see instructions)					58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					61.00
62.00	Relief payment (see instructions)					62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					1,245,083 70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					421.06 71.00
72.00	Program routine service cost (line 9 x line 71)					822,751 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)					822,751 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)					822,751 83.00
84.00	Program inpatient ancillary services (see instructions)					633,153 84.00
85.00	Utilization review - physician compensation (see instructions)					0 85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					1,455,904 86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)					0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150075 Component CCN: 155373		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1 Date/Time Prepared: 2/27/2013 3:50 pm	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150075	Period: From 10/01/2011 To 09/30/2012	Worksheet D-3 Date/Time Prepared: 2/27/2013 3:50 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		4,343,304	30.00
31.00	03100	INTENSIVE CARE UNIT		1,240,890	31.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.170313	2,030,096	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.699926	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126151	2,439,494	54.00
54.01	03630	ULTRA SOUND	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0.340875	84,488	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
60.00	06000	LABORATORY	0.114147	4,203,182	60.00
65.00	06500	RESPIRATORY THERAPY	0.231298	1,910,463	65.00
66.00	06600	PHYSICAL THERAPY	0.351740	252,210	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.128017	731,027	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.110242	1,346,967	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.248486	1,281,013	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.230838	3,071,410	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.00
76.01	03951	SLEEP LAB	0.149185	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.313708	24,976	90.00
91.00	09100	EMERGENCY	0.189710	1,299,221	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.483213	41,146	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		18,715,693	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)		18,715,693	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150075 Component CCN: 155373	Period: From 10/01/2011 To 09/30/2012	Worksheet D-3 Date/Time Prepared: 2/27/2013 3:50 pm
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.170313	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.699926	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.126151	35,757	54.00
54.01	03630 ULTRA SOUND	0.000000	0	54.01
56.00	05600 RADIOISOTOPE	0.340875	0	56.00
57.00	05700 CT SCAN	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
60.00	06000 LABORATORY	0.114147	309,626	60.00
65.00	06500 RESPIRATORY THERAPY	0.231298	365,340	65.00
66.00	06600 PHYSICAL THERAPY	0.351740	906,609	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.128017	4,009	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.110242	259,223	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.248486	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.230838	695,263	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.00
76.01	03951 SLEEP LAB	0.149185	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000 CLINIC	0.313708	1,030	90.00
91.00	09100 EMERGENCY	0.189710	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.483213	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES			95.00
200.00	Total (sum of lines 50-94 and 96-98)		2,576,857	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)		2,576,857	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150075	Period: From 10/01/2011 To 09/30/2012	Worksheet D-3 Date/Time Prepared: 2/27/2013 3:50 pm	
Cost Center Description		Title XIX	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		316,256	30.00
31.00	03100	INTENSIVE CARE UNIT		83,962	31.00
43.00	04300	NURSERY		59,712	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.170313	108,742	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.699926	9,529	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126151	149,357	54.00
54.01	03630	ULTRA SOUND	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0.340875	4,626	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
60.00	06000	LABORATORY	0.114147	252,157	60.00
65.00	06500	RESPIRATORY THERAPY	0.231298	72,427	65.00
66.00	06600	PHYSICAL THERAPY	0.351740	11,836	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.128017	29,842	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.110242	36,600	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.248486	2,621	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.230838	237,968	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.00
76.01	03951	SLEEP LAB	0.149185	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	0.313708	3,732	90.00
91.00	09100	EMERGENCY	0.189710	68,591	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.483213	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		988,028	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)		988,028	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150075	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part A Date/Time Prepared: 2/27/2013 3:50 pm
		Title XVIII	Hospital	PPS
			before 1/1	on/after 1/1
			1.00	1.01
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER PPS</b>				
1.00	DRG Amounts Other than Outlier Payments		4,719,666	1.00
2.00	Outlier payments for discharges. (see instructions)		14,580	2.00
2.01	Outlier reconciliation amount		0	2.01
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		59.28	4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment. (see instructions)		0.000000	27.00
28.00	IME Adjustment (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.50	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		17.30	31.00
32.00	Sum of lines 30 and 31		19.80	32.00
33.00	Allowable disproportionate share percentage (see instructions)		5.62	33.00
34.00	Disproportionate share adjustment (see instructions)		265,245	34.00
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0	46.00
47.00	Subtotal (see instructions)		4,999,491	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150075	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part A Date/Time Prepared: 2/27/2013 3:50 pm
		Title XVIII	Hospital	PPS
			before 1/1	on/after 1/1
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		4,999,491	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		381,412	50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0	56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).		0	57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		5,380,903	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		5,380,903	61.00
62.00	Deductibles billed to program beneficiaries		703,656	62.00
63.00	Coinurance billed to program beneficiaries		11,910	63.00
64.00	Allowable bad debts (see instructions)		4,283	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		2,998	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		4,283	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		4,668,335	67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0	68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.95	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)		4,668,335	71.00
72.00	Interim payments		4,725,007	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)		-56,672	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2		663,375	75.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0	90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the Time Value of Money		0.00	94.00
95.00	Time Value of Money for operating expenses(see instructions)		0	95.00
96.00	Time Value of Money for capital related expenses (see instructions)		0	96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150075	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part B Date/Time Prepared: 2/27/2013 3:50 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			0 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			2,660,281 2.00
3.00	PPS payments			2,641,869 3.00
4.00	Outlier payment (see instructions)			3,146 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			0 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			0 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			2,645,015 24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)			0 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			594,286 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)			2,050,729 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)			2,050,729 30.00
31.00	Primary payer payments			8,900 31.00
32.00	Subtotal (line 30 minus line 31)			2,041,829 32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			22,905 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			16,034 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			22,905 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			2,057,863 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			2,057,863 40.00
41.00	Interim payments			2,098,879 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)			-41,016 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet E-1  
Part I  
Date/Time Prepared:  
2/27/2013 3:50 pm

Title XVIII

Hospital

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,704,471		2,104,607	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	06/11/2012	20,536		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	06/11/2012	5,728	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)		20,536		-5,728	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,725,007		2,098,879	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		56,672		41,016	6.02
7.00	Total Medicare program liability (see instructions)		4,668,335		2,057,863	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: 150075 Component CCN: 155373		Period: From 10/01/2011 To 09/30/2012		Worksheet E-1 Part I Date/Time Prepared: 2/27/2013 3:50 pm	
		Title XVIII		Skilled Nursing Facility		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		614,397		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)		614,397		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		0		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		614,397		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: 150075	Period: From 10/01/2011 To 09/30/2012	Worksheet E-1 Part II Date/Time Prepared: 2/27/2013 3:50 pm
		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14		2,005	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12		3,747	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2		1,200	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12		7,796	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200		139,220,774	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20		308,174	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168		0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)		1,380,759	8.00
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)		1,492,759	30.00
31.00	Other Adjustment (specify)		0	31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)		-112,000	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150075 Component CCN: 155373	Period: From 10/01/2011 To 09/30/2012	Worksheet E-3 Part VI Date/Time Prepared: 2/27/2013 3:50 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		661,716	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)		661,716	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		47,319	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Allowable reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)		614,397	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14)		614,397	15.00
16.00	Interim payments		614,397	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)		0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2		0	19.00

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

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet G

Date/Time Prepared:  
2/27/2013 3:50 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	-516,146	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	8,310,921	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,508,635	0	0	0	6.00
7.00	Inventory	885,052	0	0	0	7.00
8.00	Prepaid expenses	215,525	0	0	0	8.00
9.00	Other current assets	1,816,192	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)	8,202,909	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	3,844,900	0	0	0	12.00
13.00	Land improvements	721,353	0	0	0	13.00
14.00	Accumulated depreciation	-219,749	0	0	0	14.00
15.00	Buildings	21,289,160	0	0	0	15.00
16.00	Accumulated depreciation	-4,891,699	0	0	0	16.00
17.00	Leasehold improvements	3,785,162	0	0	0	17.00
18.00	Accumulated depreciation	-1,712,819	0	0	0	18.00
19.00	Fixed equipment	4,029,739	0	0	0	19.00
20.00	Accumulated depreciation	-2,216,913	0	0	0	20.00
21.00	Automobiles and trucks	43,800	0	0	0	21.00
22.00	Accumulated depreciation	-41,981	0	0	0	22.00
23.00	Major movable equipment	8,875,713	0	0	0	23.00
24.00	Accumulated depreciation	-5,887,724	0	0	0	24.00
25.00	Minor equipment depreciable	379,453	0	0	0	25.00
26.00	Accumulated depreciation	-135,400	0	0	0	26.00
27.00	HIT designated Assets	2,756,284	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)	30,619,279	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	3,840,201	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,840,201	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	42,662,389	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	1,002,182	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,344,578	0	0	0	38.00
39.00	Payroll taxes payable	169,455	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	28,756,686	0	0	0	43.00
44.00	Other current liabilities	780,409	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	32,053,310	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	32,053,310	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	10,609,079				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)	10,609,079	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	42,662,389	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet G-1

Date/Time Prepared:  
2/27/2013 3:50 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		8,201,671	
2.00	Net income (loss) (From Wkst. G-3, line 29)		2,407,408			2.00
3.00	Total (sum of line 1 and line 2)		10,609,079		0	3.00
4.00		0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		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)		10,609,079		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		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)		10,609,079		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet G-1

Date/Time Prepared:  
2/27/2013 3:50 pm

	Endowment Fund		Plant Fund			
	5.00	6.00	7.00	8.00		
1.00						1.00
			0		0	
2.00						2.00
3.00			0		0	3.00
4.00	0			0		4.00
5.00	0			0		5.00
6.00	0			0		6.00
7.00	0			0		7.00
8.00	0			0		8.00
9.00	0			0		9.00
10.00			0		0	10.00
11.00			0		0	11.00
12.00	0			0		12.00
13.00	0			0		13.00
14.00	0			0		14.00
15.00	0			0		15.00
16.00	0			0		16.00
17.00	0			0		17.00
18.00			0		0	18.00
19.00			0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
2/27/2013 3:50 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	9,863,407		9,863,407	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	1,976,995		1,976,995	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	11,840,402		11,840,402	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	2,157,098		2,157,098	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	2,157,098		2,157,098	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	13,997,500		13,997,500	17.00
18.00	Ancillary services	39,952,911	72,157,592	112,110,503	18.00
19.00	Outpatient services	2,485,669	10,627,103	13,112,772	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	56,436,080	82,784,695	139,220,775	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		41,309,362		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)		41,309,362		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150075

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet G-3

Date/Time Prepared:  
2/27/2013 3:50 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	139,220,775	1.00
2.00	Less contractual allowances and discounts on patients' accounts	97,824,243	2.00
3.00	Net patient revenues (line 1 minus line 2)	41,396,532	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	41,309,362	4.00
5.00	Net income from service to patients (line 3 minus line 4)	87,170	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and 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	51,240	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	1,309	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	47,828	20.00
21.00	Rental of vending machines	1,163	21.00
22.00	Rental of hospital space	107,698	22.00
23.00	Governmental appropriations	0	23.00
24.00	<b>FITNESS REVENUE</b>	248,579	24.00
24.01	MEDICARE EHR INCENTIVE	1,367,403	24.01
24.02	MEDIAD EHR INCENTIVE	393,466	24.02
24.03	OTHER MISC REVENUE	108,827	24.03
24.04	ROUNDING	3	24.04
25.00	Total other income (sum of lines 6-24)	2,327,516	25.00
26.00	Total (line 5 plus line 25)	2,414,686	26.00
27.00	LOSS ON DISPOSAL OF FIXED ASSETS	7,278	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	7,278	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,407,408	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150075	Period: From 10/01/2011 To 09/30/2012	Worksheet L Parts I-III Date/Time Prepared: 2/27/2013 3:50 pm
		Title XVII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		379,487	1.00
2.00	Capital DRG outlier payments		1,925	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		21.30	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)		381,412	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00